

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12660 CERTIFICATE OF DEATH

Reg. Dist. No. 27 12618

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Connecticut</u> b. COUNTY <u>Hartford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Windsor</u> | |
| c. LENGTH OF STAY IN 1b <u>5 hrs 40 min</u> | | d. STREET ADDRESS <u>45X 3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>CARROLL</u> Middle <u>ALOKONIS</u> <u>Infant</u> <u>Alokonis</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 5, 1957</u> |
| 9. AGE (In years lost birthday) yrs. <u>5</u> | | IF UNDER 1 YEAR Months <u>5</u> Days <u>40</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Richard Felix Alokoni</u> | | 14. MOTHER'S MAIDEN NAME <u>Carol Ann Evans</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Father, Old Dorsey Rd, Harmans, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>Prematurity</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 hrs 40 min</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 hrs 40 min</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>5 Dec</u> , 19 <u>57</u> , to <u>5 Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 Dec</u> , 19 <u>57</u> , and that death occurred at <u>3:45 PM</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Charles F. Gill</u> M.D. <u>USAH, Ft. G. G. Meade, Maryland</u> | | DATE SIGNED <u>5 Dec 57</u> | |
| PHYSICIAN'S NAME (Type) <u>CHARLES F. GILL, Capt, MC</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12/9/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bethel National</u> | 22d. LOCATION (City, town, or county) (State) <u>2700 Federal Ge 1st Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Downs</u> ADDRESS <u>6306 Belair Rd</u> | | 24a. REC'D BY REGISTRAR <u>Walter H. Downs, Jr. Capt. MSG</u> | |
| DATE <u>6 Dec 57</u> | | 24b. REGISTRAR'S SIGNATURE | |

2050211XV1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

1557

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RECEIVED

12661

Items 4, 8, See: Birth Cert. et

CERTIFICATE OF DEATH

13801

Reg. Dist. No. 27

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Fort George G. Meade</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Albermarle</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort G. G. Meade</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlottesville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fort G. G. Meade, Md.</u> | | e. STREET ADDRESS <u>111 Goodman St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>INF MALE</u> Middle <u>ANDERSON</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 31, 1957</u> |
| 9. AGE (In years last birthday) yrs. <u>3</u> Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <u>Anderson, Albert</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Mary L. Wade</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>FATHER. 1510D Meade Dale, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x</u> DUE TO <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> (c) <u>PREMATURITY</u> | | INTERVAL BETWEEN ONSET AND DEATH. <u>3 hrs 50 min</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>31 Dec 57</u> , 19, to <u>31 Dec 57</u> , 19, that I last saw the deceased alive on <u>31 Dec 57</u> , 19, and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank L. Gruskay</u> | | ADDRESS (Street, city or town, state) <u>USA Hosp Ft 66m. Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>FRANK L. GRUSKAY</u> | | DATE SIGNED <u>31 Dec 57</u> | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-2-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Woberton Funeral Home, Inc</u> | | 24. REGISTAR'S SIGNATURE <u>WILBUR H DOWNS JR CAPT</u> | |

CERTIFICATE OF DEATH

1958

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| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | |
| 3. AGE [Faint text] | | 4. DATE OF BIRTH [Faint text] | |
| 5. PLACE OF BIRTH [Faint text] | | 6. RACE [Faint text] | |
| 7. OCCUPATION [Faint text] | | 8. MARITAL STATUS [Faint text] | |
| 9. CAUSE OF DEATH [Faint text] | | 10. PLACE OF DEATH [Faint text] | |
| 11. TIME OF DEATH [Faint text] | | 12. SIGNATURE OF DECEASED [Faint text] | |
| 13. SIGNATURE OF WITNESS [Faint text] | | 14. SIGNATURE OF DECEASED [Faint text] | |
| 15. SIGNATURE OF DECEASED [Faint text] | | 16. SIGNATURE OF DECEASED [Faint text] | |
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| 99. SIGNATURE OF DECEASED [Faint text] | | 100. SIGNATURE OF DECEASED [Faint text] | |

BUREAU V. 1

JAN 9 1958

RECEIVED

1.
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12619

Reg. Dist. No. 21

12623

| | | | |
|---|------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jonestown, Md.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Melvin Bailey</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-27-1913</u> |
| 9. AGE (In years last birthday) <u>44</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Min. <u>57</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grave Digger Wilcrest Cem.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 13. FATHER'S NAME <u>Henry Bailey</u> | | 14. MOTHER'S MAIDEN NAME <u>Ann Bailey</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>614-05-1896</u> | |
| 17. INFORMANT <u>Agnes Bailey-Jones, Md.</u> | | Address <u>Jonestown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>494.3 Cardiac Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (a), stating the underlying cause last. (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a. m. <u>10</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-11-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Stopes Chapel</u> | | 22d. LOCATION (City, town, or county) (State) <u>Edgewater, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u> | | 24a. REC'D BY REGISTRAR <u>12/10/57</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Mr. J. French</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE
DATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

RESIDENT

DECEASED

DATE OF DEATH
PLACE OF DEATH

DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF EXAMINER
DATE OF EXAMINATION

DATE OF COLLECTION

BUREAU V. S.

DEC 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12620

12624

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>AA</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Margarets</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i> | | | | d. STREET ADDRESS <i>R. 7 D. 2 Annapolis</i> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Maurice E.</i> Middle <i>Baldwin</i> Last <i>Baldwin</i> | | | | 4. DATE OF DEATH Month <i>12</i> - Day <i>31</i> Year <i>1957</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5-16-1889</i> | 9. AGE (In years last birthday) <i>68</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer (Truck)</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer (Truck)</i> | | 11. BIRTHPLACE (State or foreign country) <i>AA Co MD</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | | | | | | |
| 13. FATHER'S NAME <i>William P. Baldwin</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Amanda Statlings</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <i>Bertha W. Baldwin</i> (2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion P (DCA)</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>1-28</i> , 19 <i>55</i> , to <i>4-6</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4-6</i> , 19 <i>55</i> , and that death occurred at <i>?</i> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Frank M. Shipley</i> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED <i>1-3-58</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i> | | | | <i>Annapolis MD</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>1-3-58</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Cosbury Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Annapolis MD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons</i> | | | | ADDRESS <i>Annapolis MD</i> | | 24a. REC'D BY REGISTRAR DATE <i>1958</i> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>John J. French</i> | | | |

JAN 6 1953

REF A 13274

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>aa</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Epping Forest</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>aa</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Epping Forest</i> d. STREET ADDRESS <i>Vinyard Trail</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Velma</i> Middle <i>Ann</i> Last <i>Barry</i> | | 4. DATE OF DEATH Month <i>12</i> - Day <i>13</i> Year <i>1957</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Aug 24 - 1868</i> |
| 9. AGE (In years last birthday) <i>89</i> yrs. | | 10. IF UNDER 1 YEAR Months <i>8</i> Days <i>13</i> | 11. IF UNDER 24 HRS. Hours <i>13</i> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | 11. BIRTHPLACE (State or foreign country) <i>Potsdam N.Y.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>James Mc Cormick</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | |
| 16. SOCIAL SECURITY NO. <i>-</i> | | 17. INFORMANT <i>Edwin M. Barry</i> Address <i>(2)</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.3</i> DUE TO <i>Cardiac Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> | | DATE SIGNED <i>12/13/57</i> | |
| EXAMINER'S NAME (Type) <i>F. F. W. H. A. S. T.</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | 22b. DATE THEREOF <i>12-15-57</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Bay Side Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Potsdam N.Y.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Kelly Jr Sons</i> | | 24a. REC'D BY REGISTRAR <i>U. V. D. Smith</i> | |
| ADDRESS <i>Annapolis Md</i> | | 24b. REGISTRAR'S SIGNATURE | |
| DATE <i>12/16/57</i> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1957

Page 1 of 2

| | | | |
|---|--|--|--|
| <p>1. Name of Deceased: _____</p> | | <p>2. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> | |
| <p>3. Date of Birth: _____</p> | | <p>4. Place of Birth: _____</p> | |
| <p>5. Date of Death: _____</p> | | <p>6. Place of Death: _____</p> | |
| <p>7. Cause of Death: _____</p> | | <p>8. Manner of Death: _____</p> | |
| <p>9. Signature of Examiner: _____</p> | | <p>10. Signature of Coroner: _____</p> | |
| <p>11. Signature of Physician: _____</p> | | <p>12. Signature of Medical Examiner: _____</p> | |
| <p>13. Signature of Medical Examiner: _____</p> | | <p>14. Signature of Medical Examiner: _____</p> | |
| <p>15. Signature of Medical Examiner: _____</p> | | <p>16. Signature of Medical Examiner: _____</p> | |
| <p>17. Signature of Medical Examiner: _____</p> | | <p>18. Signature of Medical Examiner: _____</p> | |
| <p>19. Signature of Medical Examiner: _____</p> | | <p>20. Signature of Medical Examiner: _____</p> | |
| <p>21. Signature of Medical Examiner: _____</p> | | <p>22. Signature of Medical Examiner: _____</p> | |
| <p>23. Signature of Medical Examiner: _____</p> | | <p>24. Signature of Medical Examiner: _____</p> | |
| <p>25. Signature of Medical Examiner: _____</p> | | <p>26. Signature of Medical Examiner: _____</p> | |
| <p>27. Signature of Medical Examiner: _____</p> | | <p>28. Signature of Medical Examiner: _____</p> | |
| <p>29. Signature of Medical Examiner: _____</p> | | <p>30. Signature of Medical Examiner: _____</p> | |
| <p>31. Signature of Medical Examiner: _____</p> | | <p>32. Signature of Medical Examiner: _____</p> | |
| <p>33. Signature of Medical Examiner: _____</p> | | <p>34. Signature of Medical Examiner: _____</p> | |
| <p>35. Signature of Medical Examiner: _____</p> | | <p>36. Signature of Medical Examiner: _____</p> | |
| <p>37. Signature of Medical Examiner: _____</p> | | <p>38. Signature of Medical Examiner: _____</p> | |
| <p>39. Signature of Medical Examiner: _____</p> | | <p>40. Signature of Medical Examiner: _____</p> | |
| <p>41. Signature of Medical Examiner: _____</p> | | <p>42. Signature of Medical Examiner: _____</p> | |
| <p>43. Signature of Medical Examiner: _____</p> | | <p>44. Signature of Medical Examiner: _____</p> | |
| <p>45. Signature of Medical Examiner: _____</p> | | <p>46. Signature of Medical Examiner: _____</p> | |
| <p>47. Signature of Medical Examiner: _____</p> | | <p>48. Signature of Medical Examiner: _____</p> | |
| <p>49. Signature of Medical Examiner: _____</p> | | <p>50. Signature of Medical Examiner: _____</p> | |
| <p>51. Signature of Medical Examiner: _____</p> | | <p>52. Signature of Medical Examiner: _____</p> | |
| <p>53. Signature of Medical Examiner: _____</p> | | <p>54. Signature of Medical Examiner: _____</p> | |
| <p>55. Signature of Medical Examiner: _____</p> | | <p>56. Signature of Medical Examiner: _____</p> | |
| <p>57. Signature of Medical Examiner: _____</p> | | <p>58. Signature of Medical Examiner: _____</p> | |
| <p>59. Signature of Medical Examiner: _____</p> | | <p>60. Signature of Medical Examiner: _____</p> | |
| <p>61. Signature of Medical Examiner: _____</p> | | <p>62. Signature of Medical Examiner: _____</p> | |
| <p>63. Signature of Medical Examiner: _____</p> | | <p>64. Signature of Medical Examiner: _____</p> | |
| <p>65. Signature of Medical Examiner: _____</p> | | <p>66. Signature of Medical Examiner: _____</p> | |
| <p>67. Signature of Medical Examiner: _____</p> | | <p>68. Signature of Medical Examiner: _____</p> | |
| <p>69. Signature of Medical Examiner: _____</p> | | <p>70. Signature of Medical Examiner: _____</p> | |
| <p>71. Signature of Medical Examiner: _____</p> | | <p>72. Signature of Medical Examiner: _____</p> | |
| <p>73. Signature of Medical Examiner: _____</p> | | <p>74. Signature of Medical Examiner: _____</p> | |
| <p>75. Signature of Medical Examiner: _____</p> | | <p>76. Signature of Medical Examiner: _____</p> | |
| <p>77. Signature of Medical Examiner: _____</p> | | <p>78. Signature of Medical Examiner: _____</p> | |
| <p>79. Signature of Medical Examiner: _____</p> | | <p>80. Signature of Medical Examiner: _____</p> | |
| <p>81. Signature of Medical Examiner: _____</p> | | <p>82. Signature of Medical Examiner: _____</p> | |
| <p>83. Signature of Medical Examiner: _____</p> | | <p>84. Signature of Medical Examiner: _____</p> | |
| <p>85. Signature of Medical Examiner: _____</p> | | <p>86. Signature of Medical Examiner: _____</p> | |
| <p>87. Signature of Medical Examiner: _____</p> | | <p>88. Signature of Medical Examiner: _____</p> | |
| <p>89. Signature of Medical Examiner: _____</p> | | <p>90. Signature of Medical Examiner: _____</p> | |
| <p>91. Signature of Medical Examiner: _____</p> | | <p>92. Signature of Medical Examiner: _____</p> | |
| <p>93. Signature of Medical Examiner: _____</p> | | <p>94. Signature of Medical Examiner: _____</p> | |
| <p>95. Signature of Medical Examiner: _____</p> | | <p>96. Signature of Medical Examiner: _____</p> | |
| <p>97. Signature of Medical Examiner: _____</p> | | <p>98. Signature of Medical Examiner: _____</p> | |
| <p>99. Signature of Medical Examiner: _____</p> | | <p>100. Signature of Medical Examiner: _____</p> | |

BUREAU V. 2

DEC 18 1957

RECEIVED

12663 CERTIFICATE OF DEATH

Reg. Dist. No. 27

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maine b. COUNTY Cumberland ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade | | | | c. LENGTH OF STAY IN 1b 6 Months | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portland 57X-3 | | | | d. STREET ADDRESS 81 Ocean Street | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First NAKA Middle KATO Last BENNETT | | | | 4. DATE OF DEATH Month December Day 16 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Mong | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 23 April 1923 | |
| 9. AGE (In years last birthday) 34 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Japan | |
| 12. CITIZEN OF WHAT COUNTRY? Japan ✓ | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Husband, Sgt Bennett, 1709 D Forrest Avenue | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach with peritoneal dissemination 151X DUE TO (b) Gastroenterostomy, ruptured Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Purulent peritonitis | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 4 Dec , 19 57 , to 16 Dec , 19 57 , that I last saw the deceased alive on 16 Dec , 19 57 , and that death occurred at 0445 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) USA, Ft. G. G. Meade, Md. DATE SIGNED 16 Dec 57 | | | | | | | |
| ACTUAL SIGNATURE Kenwyn G. Nelson M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) KENWYN G. NELSON, Maj, MC | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 12-17-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Frank Hobbs Funeral Home | | 22d. LOCATION (City, town or county) (State) South Portland, Maine | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Woberton Funeral Home, Inc | | | | 24a. REC'D BY REGISTRAR DATE 16 Dec 57 | | 24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSC | |

6306-Belair Rd - Baltimore - 6, Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

DEC 19 1957

REGENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12664 CERTIFICATE OF DEATH

12623

Reg. Dist. No.

| | | | |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>17 A</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWENSVILLE</u> | | c. LENGTH OF STAY IN 1b <u>30 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 OWENSVILLE</u> | |
| | | d. STREET ADDRESS <u>1</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM WHITTINGHAM Billard</u> | | 4. DATE OF DEATH Month Day Year <u>Dec 15 1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/20/80</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COAL MERCHANT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>COAL</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Laurel Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jules Frederic Billard</u> | | 14. MOTHER'S MAIDEN NAME <u>Lillian K. Johnson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>212 01164A</u> | |
| 17. INFORMANT <u>Major Jules F. Millard Fort Knox, Ky.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVR Disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>8 yrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Dec 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 Dec</u> , 19 <u>57</u> , and that death occurred at <u>1:15 A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R. B. Lamer</u> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Upper Marlboro Md 12 Dec 57</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12/17/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u> | 22d. LOCATION (City, town, or county) (State) <u>OWENSVILLE Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty Salazar</u> | | ADDRESS <u>used</u> | |
| 24a. REC'D BY REGISTRAR <u>23 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Carl Smith</u> | |

1752-1753 1754-1755 1756-1757 1758-1759 1760-1761 1762-1763 1764-1765 1766-1767 1768-1769 1770-1771 1772-1773 1774-1775 1776-1777 1778-1779 1780-1781 1782-1783 1784-1785 1786-1787 1788-1789 1790-1791 1792-1793 1794-1795 1796-1797 1798-1799 1800-1801 1802-1803 1804-1805 1806-1807 1808-1809 1810-1811 1812-1813 1814-1815 1816-1817 1818-1819 1820-1821 1822-1823 1824-1825 1826-1827 1828-1829 1830-1831 1832-1833 1834-1835 1836-1837 1838-1839 1840-1841 1842-1843 1844-1845 1846-1847 1848-1849 1850-1851 1852-1853 1854-1855 1856-1857 1858-1859 1860-1861 1862-1863 1864-1865 1866-1867 1868-1869 1870-1871 1872-1873 1874-1875 1876-1877 1878-1879 1880-1881 1882-1883 1884-1885 1886-1887 1888-1889 1890-1891 1892-1893 1894-1895 1896-1897 1898-1899 1900-1901 1902-1903 1904-1905 1906-1907 1908-1909 1910-1911 1912-1913 1914-1915 1916-1917 1918-1919 1920-1921 1922-1923 1924-1925 1926-1927 1928-1929 1930-1931 1932-1933 1934-1935 1936-1937 1938-1939 1940-1941 1942-1943 1944-1945 1946-1947 1948-1949 1950-1951 1952-1953 1954-1955 1956-1957 1958-1959 1960-1961 1962-1963 1964-1965 1966-1967 1968-1969 1970-1971 1972-1973 1974-1975 1976-1977 1978-1979 1980-1981 1982-1983 1984-1985 1986-1987 1988-1989 1990-1991 1992-1993 1994-1995 1996-1997 1998-1999 2000-2001 2002-2003 2004-2005 2006-2007 2008-2009 2010-2011 2012-2013 2014-2015 2016-2017 2018-2019 2020-2021 2022-2023 2024-2025 2026-2027 2028-2029 2030-2031 2032-2033 2034-2035 2036-2037 2038-2039 2040-2041 2042-2043 2044-2045 2046-2047 2048-2049 2050-2051 2052-2053 2054-2055 2056-2057 2058-2059 2060-2061 2062-2063 2064-2065 2066-2067 2068-2069 2070-2071 2072-2073 2074-2075 2076-2077 2078-2079 2080-2081 2082-2083 2084-2085 2086-2087 2088-2089 2090-2091 2092-2093 2094-2095 2096-2097 2098-2099 2100-2101 2102-2103 2104-2105 2106-2107 2108-2109 2110-2111 2112-2113 2114-2115 2116-2117 2118-2119 2120-2121 2122-2123 2124-2125 2126-2127 2128-2129 2130-2131 2132-2133 2134-2135 2136-2137 2138-2139 2140-2141 2142-2143 2144-2145 2146-2147 2148-2149 2150-2151 2152-2153 2154-2155 2156-2157 2158-2159 2160-2161 2162-2163 2164-2165 2166-2167 2168-2169 2170-2171 2172-2173 2174-2175 2176-2177 2178-2179 2180-2181 2182-2183 2184-2185 2186-2187 2188-2189 2190-2191 2192-2193 2194-2195 2196-2197 2198-2199 2200-2201 2202-2203 2204-2205 2206-2207 2208-2209 2210-2211 2212-2213 2214-2215 2216-2217 2218-2219 2220-2221 2222-2223 2224-2225 2226-2227 2228-2229 2230-2231 2232-2233 2234-2235 2236-2237 2238-2239 2240-2241 2242-2243 2244-2245 2246-2247 2248-2249 2250-2251 2252-2253 2254-2255 2256-2257 2258-2259 2260-2261 2262-2263 2264-2265 2266-2267 2268-2269 2270-2271 2272-2273 2274-2275 2276-2277 2278-2279 2280-2281 2282-2283 2284-2285 2286-2287 2288-2289 2290-2291 2292-2293 2294-2295 2296-2297 2298-2299 2300-2301 2302-2303 2304-2305 2306-2307 2308-2309 2310-2311 2312-2313 2314-2315 2316-2317 2318-2319 2320-2321 2322-2323 2324-2325 2326-2327 2328-2329 2330-2331 2332-2333 2334-2335 2336-2337 2338-2339 2340-2341 2342-2343 2344-2345 2346-2347 2348-2349 2350-2351 2352-2353 2354-2355 2356-2357 2358-2359 2360-2361 2362-2363 2364-2365 2366-2367 2368-2369 2370-2371 2372-2373 2374-2375 2376-2377 2378-2379 2380-2381 2382-2383 2384-2385 2386-2387 2388-2389 2390-2391 2392-2393 2394-2395 2396-2397 2398-2399 2400-2401 2402-2403 2404-2405 2406-2407 2408-2409 2410-2411 2412-2413 2414-2415 2416-2417 2418-2419 2420-2421 2422-2423 2424-2425 2426-2427 2428-2429 2430-2431 2432-2433 2434-2435 2436-2437 2438-2439 2440-2441 2442-2443 2444-2445 2446-2447 2448-2449 2450-2451 2452-2453 2454-2455 2456-2457 2458-2459 2460-2461 2462-2463 2464-2465 2466-2467 2468-2469 2470-2471 2472-2473 2474-2475 2476-2477 2478-2479 2480-2481 2482-2483 2484-2485 2486-2487 2488-2489 2490-2491 2492-2493 2494-2495 2496-2497 2498-2499 2500-2501 2502-2503 2504-2505 2506-2507 2508-2509 2510-2511 2512-2513 2514-2515 2516-2517 2518-2519 2520-2521 2522-2523 2524-2525 2526-2527 2528-2529 2530-2531 2532-2533 2534-2535 2536-2537 2538-2539 2540-2541 2542-2543 2544-2545 2546-2547 2548-2549 2550-2551 2552-2553 2554-2555 2556-2557 2558-2559 2560-2561 2562-2563 2564-2565 2566-2567 2568-2569 2570

BUREAU V. S.

DEC 23 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, Film G224 1-3-58 et

12625

CERTIFICATE OF DEATH

Reg. Dist. No.

12624

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|--|------------------------------|---|-------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. LENGTH OF STAY IN 1b <u>32 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>H</u> Last <u>Bolander</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>57</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/17/97</u> | 9. AGE (In years last birthday) <u>66</u> yrs. | IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>9</u> Min. | IF UNDER 24 HRS. Months <u>6</u> Days <u>9</u> Hours <u>9</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Library Custodian</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Naval Academy</u> | | 11. BIRTHPLACE (State or foreign country) <u>Warterloo, New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>LIBRARIAN</u> <u>Henry Bolander</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Louise Adair</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT <u>Edith N. Bolander, wife</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO (b) <u>Thrombosis, right middle cerebral artery</u> (c) <u>Generalized arteriosclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 da.</u> <u>4 da.</u> <u>unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12/8</u> , 19 <u>57</u> , to <u>12/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>57</u> , and that death occurred at <u>2:09 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>68 Franklin St. Annapolis, Maryland</u> DATE SIGNED <u>12/12/57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Richard N. Peeler</u> | | M.D. <u>68 Franklin St. Annapolis, Maryland</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>Richard N. Peeler, M. D.</u> | | Annapolis, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-16-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Sayles Sons</u> | | ADDRESS <u>Annapolis Md</u> | | 24a. REC'D BY REGISTRAR <u>12/12/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>U. S. Naval</u> | |

CERTIFICATE OF DEATH

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| 1. Name of deceased | | 2. Sex | | 3. Race | | 4. Date of birth | | 5. Place of birth | | 6. Usual residence | | 7. Date of death | | 8. Place of death | | 9. Cause of death | | 10. Manner of death | | 11. Signature of physician | | 12. Signature of registrar | | 13. Date of registration | | 14. Registrar's office | |
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12626

CERTIFICATE OF DEATH

12625

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. General Hosp</u> | | d. STREET ADDRESS <u>150 Murray Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Jena</u> Middle <u>E.</u> Last <u>Brewer</u> | | 4. DATE OF DEATH Month <u>12</u> - Day <u>11</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-15-1896</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Fayetteville N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Weldon Evans</u> | | 14. MOTHER'S MAIDEN NAME <u>Josephine Jones</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Master S. Brewer</u> | | Address <u>(2)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>10 YRS</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>24 HOURS</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>DEC</u> , 1956, to <u>11 DEC</u> , 1957, that I last saw the deceased alive on <u>11 DEC</u> , 1957, and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u> DATE SIGNED <u>12/12/57</u> ACTUAL SIGNATURE <u>Edward A. Beck</u> M.D. PHYSICIAN'S NAME (Type) <u>Annapolis Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 22b. DATE THEREOF <u>12-12-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt View Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Danville Va</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u> | | 24a. REC'D BY REGISTRAR <u>12/12/57</u> | |
| ADDRESS <u>Annapolis Md</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12665 CERTIFICATE OF DEATH

12626

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Truck House Rd.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Truck House Rd.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Carl</u> First <u>Bernard</u> Middle <u>Broedner</u> Last | | | | 4. DATE OF DEATH <u>Dec 29</u> 19 <u>57</u> Month Day Year | | | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 30, 1886</u> 7/ yrs. | |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>2 Mechanist</u> | | 11. BIRTHPLACE (State or foreign country) <u>Machine Shop - Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Carl Bernard Broedner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT <u>wife</u> | | Address <u>Severna Park Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart Failure</u> DUE TO <u>Coronary Pericarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>57</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>Dec 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 29</u> , 19 <u>57</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>12-29-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u> | | | | <u>Severna Park MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-28-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u> ADDRESS <u>130 E. Fort me.</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 31 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>L. J. Healy</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

DEC 31 1957

RECEIVED

| | | | |
|--|--|-----------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| PLACE OF DEATH | | AGE | |
| OCCUPATION | | SEX | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF REGISTRAR | | DATE | |
| SIGNATURE OF WITNESS | | DATE | |
| SIGNATURE OF PHYSICIAN | | DATE | |
| SIGNATURE OF CLERK | | DATE | |
| SIGNATURE OF JUDGE | | DATE | |
| SIGNATURE OF SHERIFF | | DATE | |
| SIGNATURE OF CORONER | | DATE | |
| SIGNATURE OF DISTRICT ATTORNEY | | DATE | |
| SIGNATURE OF COUNTY CLERK | | DATE | |
| SIGNATURE OF TOWNSHIP CLERK | | DATE | |
| SIGNATURE OF VOTING CLERK | | DATE | |
| SIGNATURE OF POLLING CLERK | | DATE | |
| SIGNATURE OF BALLOT CLERK | | DATE | |
| SIGNATURE OF CANVASSER | | DATE | |
| SIGNATURE OF JURY CLERK | | DATE | |
| SIGNATURE OF COURT CLERK | | DATE | |
| SIGNATURE OF CLERK OF SUPERIOR COURT | | DATE | |
| SIGNATURE OF CLERK OF DISTRICT COURT | | DATE | |
| SIGNATURE OF CLERK OF COUNTY COURT | | DATE | |
| SIGNATURE OF CLERK OF JUDICIAL CIRCUIT | | DATE | |
| SIGNATURE OF CLERK OF APPELLATE COURT | | DATE | |
| SIGNATURE OF CLERK OF SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF COLUMBIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF COLUMBIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF MARYLAND | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF MARYLAND | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF VIRGINIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF VIRGINIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF NORTH CAROLINA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF NORTH CAROLINA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF SOUTH CAROLINA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF SOUTH CAROLINA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF GEORGIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF GEORGIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF ALABAMA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF ALABAMA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF LOUISIANA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF LOUISIANA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF MISSISSIPPI | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF MISSISSIPPI | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF ARIZONA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF ARIZONA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF CALIFORNIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF CALIFORNIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF NEVADA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF NEVADA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF IDAHO | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF IDAHO | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF MONTANA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF MONTANA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF WYOMING | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF WYOMING | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF UTAH | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF UTAH | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF NEW MEXICO | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF NEW MEXICO | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF COLORADO | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF COLORADO | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF KANSAS | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF KANSAS | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF OKLAHOMA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF OKLAHOMA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF TEXAS | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF TEXAS | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF MINNESOTA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF MINNESOTA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF IOWA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF IOWA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF NEBRASKA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF NEBRASKA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF MISSOURI | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF MISSOURI | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF ILLINOIS | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF ILLINOIS | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF INDIANA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF INDIANA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF OHIO | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF OHIO | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF PENNSYLVANIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF PENNSYLVANIA | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF NEW JERSEY | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF NEW JERSEY | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF DELAWARE | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF DELAWARE | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |
| SIGNATURE OF CLERK OF U.S. DISTRICT COURT FOR DISTRICT OF MARYLAND | | DATE | |
| SIGNATURE OF CLERK OF U.S. COURT OF APPEALS FOR DISTRICT OF MARYLAND | | DATE | |
| SIGNATURE OF CLERK OF U.S. SUPREME COURT | | DATE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12666 CERTIFICATE OF DEATH

12628

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> | | c. LENGTH OF STAY IN 1b <u>3 yr, 10 mo & 8 da</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | 3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Brown</u> Last <u>Brown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u> | | d. STREET ADDRESS <u>904 E. North Ave.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>19 57</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/15/1882</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Walter Dashields</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT <u>Hospital Records</u> | | Address _____ | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia and Hypostatic Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pyelonephritis</u> DUE TO (c) <u>Left Hemiplegia</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Arteriosclerosis</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Feb. 9</u> , 19 <u>54</u> , to <u>December 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 17</u> , 19 <u>57</u> , and that death occurred at <u>11:45 A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Ludwig Benedict</u> M.D. <u>Crownsville, Md.</u> <u>12/18/57</u> PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D.</u> <u>Crownsville State Hospital, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec. 21, 1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Brookland; Anne Arundel Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Roy O. Wilson</u> | | 24a. REC'D BY REGISTRAR <u>DEC 26 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>A. M. J. J.</u> | | | |

12627 CERTIFICATE OF DEATH

Reg. Dist. No.

21

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Street River</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Epoch</u> Middle <u>Camphor</u> Last <u>Camphor</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-12-1879</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>State D. Comm</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>?</u> | | 14. MOTHER'S MAIDEN NAME <u>Fannie Camphor</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Allen Camphor</u> Address <u>Arundel, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>central vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension</u> DUE TO (c) <u>generalized arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>12-13</u> , 19 <u>57</u> , to <u>Dec. 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-15</u> , 19 <u>57</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Emily H. Nelson</u> M.D. | | ADDRESS (Street, city or town, state) <u>Sutton, Md.</u> DATE SIGNED <u>12-16-57</u> | |
| PHYSICIAN'S NAME (Type) <u>William Deese, Jr. - Annapolis, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>12-19-57</u> | <u>St. Johns Chapel</u> | <u>Quiversville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Deese, Jr.</u> ADDRESS <u>Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE |
| | | <u>DATE 12/18/57</u> | <u>John J. French</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12628

CERTIFICATE OF DEATH

Reg. Dist. No. 12629

| | | | | | | | |
|--|----------------------------------|--|-------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Ala</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Ala</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chinnapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chinnapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ala. General</u> | | | | d. STREET ADDRESS <u>Crundel Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>E.</u> Last <u>Chaney</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-9-1888</u> | 9. AGE (In years lost birthday) yrs. <u>69</u> | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Care taken of old</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Caretaker (Est)</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ala Co Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | | | |
| 13. FATHER'S NAME <u>Richard Chaney</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Florence Wood</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>214-05-2862</u> | | 17. INFORMANT <u>Frederick Chaney</u> | | Address <u>(2)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Emphysema</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>20 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular accident</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Dec. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 24</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John H. Hedman</u> | | | | M.D. <u>12/27/57</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-27-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cent</u> | | 22d. LOCATION (City, town, or county) (State) <u>Chinnapolis Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> | | | | ADDRESS <u>Chinnapolis</u> | | 24a. REC'D BY REGISTRAR DATE <u>12/27/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>V. V. V.</u> | | | |

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

DEC 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

12630

| | | | |
|--|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendship A. A. Co.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armed General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Beance</u> Middle <u>Coates</u> Last <u>Coates</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-20-1901</u> |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min. <u>56</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>house wife</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Isaac Rawlins</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Smith</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Leonard Coates</u> | | Address <u>Friendship A. A. Co.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cystic Tumor of Cerebellum</u> 257x DUE TO <u>Type to be determined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Type to be determined</u> DUE TO (c) <u>Type to be determined</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>about 2 hrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 28, 1957</u> to <u>Nov 20, 1957</u> , that I last saw the deceased alive on <u>Nov 28, 1957</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <u>110-Clay Street, Baltimore, Md.</u> | |
| ACTUAL SIGNATURE <u>R. L. Richardson</u> | | DATE SIGNED <u>12/26/57</u> | |
| PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-23-57</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>mt hope</u> | | 22d. LOCATION (City, town, or county) (State) <u>Sundaland Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> | | ADDRESS <u>Prince Fred, Md</u> | |
| 24a. REC'D BY REGISTRAR <u>12-26-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>H. C. Wark</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---------------------------------------|--|---|--|
| PLACE OF DEATH HOME | | MANNER OF DEATH ACCIDENT | |
| DATE OF DEATH DEC 27 1911 | | TIME OF DEATH 10:00 AM | |
| PLACE OF BIRTH BALTIMORE, MARYLAND | | AGE 45 | |
| SEX MALE | | COLOR WHITE | |
| OCCUPATION LABORER | | CAUSE OF DEATH HEART DISEASE | |
| DISEASE OR INJURY HEART DISEASE | | MEDICAL HISTORY NONE | |
| PREVIOUS ILLNESS NONE | | MEDICAL OPINION HEART DISEASE | |
| SIGNATURE OF PHYSICIAN J. H. BROWN | | SIGNATURE OF DEATH REGISTRAR J. H. BROWN | |
| SIGNATURE OF WITNESS J. H. BROWN | | SIGNATURE OF WITNESS J. H. BROWN | |

RECEIVED
 DEC 27 1911
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12630

CERTIFICATE OF DEATH

12631

Reg. Dist. No. 21

| | | | |
|--|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH o. COUNTY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS. | |
| c. LENGTH OF STAY IN 1b 15 YRS. | | d. STREET ADDRESS 1500 WEST ST. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSP | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GRACE A. CRITZER | | 4. DATE OF DEATH Month Day Year 12 3 1957 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/14/96 |
| 9. AGE (In years last birthday) yrs. 61 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY VA. | |
| 11. BIRTHPLACE (State or foreign country) USA. | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME CHARLES C. REID | | 14. MOTHER'S MAIDEN NAME MARE ELIZABETH LOVELY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. LUTHER E CRITZER, ANNAPOLIS, MD. | |
| 17. INFORMANT Address LUTHER E CRITZER, ANNAPOLIS, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT CEREBRAL ARTERY THROMBOSIS DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 PM. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PERIPHERAL NEURITIS DUE TO DIETARY INSUFFICIENCY 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/6 , 19 57 , to 12/3 , 19 57 , that I last saw the deceased alive on 12/3 , 19 57 , and that death occurred at 5:16 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 68 Franklin St DATE SIGNED ACTUAL SIGNATURE Richard N. Peeler M.D. Annnapolis, Md. PHYSICIAN'S NAME (Type) RICHARD N. PEELER | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-6-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | | 22d. LOCATION (City, town, or county) (State) Annapolis, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Md. | | 24a. REC'D BY REGISTRAR DEC 9 1957 | |
| 24b. REGISTRAR'S SIGNATURE Tom French | | | |

BUREAU V. S.

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12631 CERTIFICATE OF DEATH

12632

Reg. Dist. No. 21

| | | | | | | | |
|---|---|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | | | c. LENGTH OF STAY IN TB <u>23 Years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ PAROLE</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH ANNAPOLIS, MD.</u> | | | | d. STREET ADDRESS <u>HOMEPORT FARM</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>LESLIE</u> Middle <u>CHARLES</u> Last <u>DAVIS</u> | | 4. DATE OF DEATH Month <u>DEC</u> Day <u>6</u> Year <u>19 57</u> | | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cau</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-27-1885</u> | 9. AGE (In years last birthday) <u>72</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u> | | 11. BIRTHPLACE (State or foreign country) <u>OREGON</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>WILLIAM DAVIS</u> | | | 14. MOTHER'S MAIDEN NAME <u>ADLINE WARD</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>USNH ANNAPOLIS, MARYLAND</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <u>153X</u> IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, Sigmoid Colon</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from <u>5 December, 19 57</u> , to <u>6 December, 19 57</u> , that I last saw the deceased alive on <u>6 December, 19 57</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Robert J. Busse, Jr.</u> M.D. <u>U.S. Naval Hospital, Annapolis, Md. 12-6-57</u> PHYSICIAN'S NAME (Type) <u>Robert J. BUSSE, Jr.</u> <u>Lieutenant, Medical Corps, U.S. Navy</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Dec. 10, 1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> | | ADDRESS <u>Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 9 1957</u> | 24b. REGISTRAR'S SIGNATURE <u>M. J. Hunch</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

1957

See Day 10

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------------|--|-------------------------------|--|--------------------------------------|--|-----------------------------|--|-----------------------------------|--|-----------------------------|--|---------------------------------|--|-------------------------------|--|----------------------------|--|-----------------------------------|--|-----------------------------------|--|-----------------------------------|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | | <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | | <p>5. PLACE OF BIRTH</p> | | <p>6. DATE OF DEATH</p> | | <p>7. PLACE OF DEATH</p> | | <p>8. CAUSE OF DEATH</p> | | <p>9. MANNER OF DEATH</p> | | <p>10. SIGNATURE OF PHYSICIAN</p> | | <p>11. SIGNATURE OF REGISTRAR</p> | | <p>12. SIGNATURE OF WITNESSES</p> | |
| <p>13. OCCUPATION</p> | | <p>14. EDUCATION</p> | | <p>15. RELIGION</p> | | <p>16. MARITAL STATUS</p> | | <p>17. SOCIAL SECURITY NUMBER</p> | | <p>18. RACE</p> | | <p>19. COLOR</p> | | <p>20. HEIGHT</p> | | <p>21. WEIGHT</p> | | <p>22. BLOOD TYPE</p> | | <p>23. HUSBAND'S NAME</p> | | <p>24. WIFE'S NAME</p> | |
| <p>25. DATE OF INTERMENT</p> | | <p>26. PLACE OF INTERMENT</p> | | <p>27. NAME OF INTERMENT SOCIETY</p> | | <p>28. NAME OF MINISTER</p> | | <p>29. NAME OF CHURCH</p> | | <p>30. NAME OF CEMETERY</p> | | <p>31. NAME OF FUNERAL HOME</p> | | <p>32. NAME OF UNDERTAKER</p> | | <p>33. NAME OF CARRIER</p> | | <p>34. NAME OF COFFIN</p> | | <p>35. NAME OF CASK</p> | | <p>36. NAME OF CASK</p> | |

BUREAU V. S.

DEC 30 1957

RECEIVED

INSTRUCTIONS

1
 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The form copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 21 Film 223 12-23-57 ams

CERTIFICATE OF DEATH

12634

Reg. Dist. No. 21

12633

Item 2 Film 223 12-13-57 et

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | | STATE <u>Massachusetts</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u> | | LENGTH OF STAY (in this place) <u>1 year</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis / Medford</u> | | <u>58x.3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Academy</u> | | | | STREET ADDRESS <u>Annapolis, Maryland</u> <u>60 Woburn Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Joseph</u> (Middle) <u>Alfred</u> (Last) <u>DeMasi</u> | | | | (Month) <u>Dec.</u> (Day) <u>7</u> (Year) <u>19 57</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>February 1 1938</u> | 9. AGE last birthday <u>19</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Midshipman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u> | | 11. BIRTHPLACE (State or foreign country) <u>New Haven, Connecticut</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Joseph D. DeMasi</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Gertrude Bond DeMasi</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>015-30-0620</u> | | 17. INFORMANT & ADDRESS <u>U.S. Navy Records</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 974X IMMEDIATE CAUSE (A) <u>Strangulation</u> | | | | | | <u>Unknown</u> | |
| DUE TO ANTECEDENT CAUSE(S) (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>Swiss</u> | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Dormitory</u> | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Annapolis Anne Arundel Maryland</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>December 7 1957 0:40</u> M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Investigation being conducted / Unpremeditated suicide</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>12-7</u> , 19 <u>57</u> , to <u>12-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-7</u> , 19 <u>57</u> , and that death occurred at <u>0:40</u> A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Maynard L. Sisler</u> | | | | ADDRESS (Street, city, town, state) <u>U.S. Naval Academy, Annapolis, Md</u> | | | |
| Maynard L. Sisler, LT, MC, USN | | | | DATE SIGNED <u>12-7-57</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u> | | DATE THEREOF <u>12-8-57</u> | | NAME OF CEMETERY OR CREMATORY <u>Medford, Massachusetts</u> | | LOCATION (City, town, or county) (State) | |
| 24. REC'D BY REGISTRAR <u>DEC 11 1957</u> | | REGISTRAR'S SIGNATURE <u>Wm. J. French</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> | | ADDRESS <u>Annapolis, Md.</u> | |

RECEIVED

12634

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. County</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ad. County</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian, P.O.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad. General Hospital</u> | | | | d. STREET ADDRESS <u>1</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Florence Dorsey</u> | | | | 4. DATE OF DEATH | | Month <u>12</u> Day <u>5</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Caucasian</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-15-1919</u> | |
| 9. AGE (In years last birthday) <u>38</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME <u>Robert Selman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>7</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Ruth Selman</u> Address <u>Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>951x Anaphylactic Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Penicillin (over response)</u> DUE TO (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>11-5-57</u> , 19 <u> </u> , to <u>12-5-57</u> , 19 <u> </u> , that I lost saw the deceased alive on <u>12-5-57</u> , 19 <u> </u> , and that death occurred at <u>1:50</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W. T. Allen</u> | | | | ADDRESS (Street, city or town, state) <u>612 Cathedral St</u> DATE SIGNED <u>12-7-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A T ALLEN</u> | | | | ADDRESS <u>Annapolis and</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>12-9-1957</u> | | <u>Moses</u> | | <u>Annapolis Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beckett</u> ADDRESS <u>108 Wash. St. Annapolis, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>DEC 9 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Beckett</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

RECEIVED
 DEC 10 1957
 BUREAU V. S.

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | |
| 4. DATE OF DEATH [Faint text] | | 5. TIME OF DEATH [Faint text] | | 6. PLACE OF DEATH [Faint text] | |
| 7. CAUSE OF DEATH [Faint text] | | 8. MANNER OF DEATH [Faint text] | | 9. SIGNATURE OF DECEASED [Faint text] | |
| 10. SIGNATURE OF WITNESS [Faint text] | | 11. SIGNATURE OF PHYSICIAN [Faint text] | | 12. SIGNATURE OF CORONER [Faint text] | |
| 13. SIGNATURE OF JUDGE [Faint text] | | 14. SIGNATURE OF CLERK [Faint text] | | 15. SIGNATURE OF REGISTRAR [Faint text] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12636

12667 CERTIFICATE OF DEATH

Reg. Dist. No. 24

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harundale, Glen Burnie</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harundale, Glen Burnie x2</u> | | | |
| c. LENGTH OF STAY IN 1b <u>7 1/2 mos</u> | | | | d. STREET ADDRESS <u>816 Dale Road</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>816 Dale Road</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Wilbur</u> Middle <u>Frederick</u> Last <u>Emge, Jr.</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 16, 1899</u> | 9. AGE (In years last birthday) <u>58</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman (ret.)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hughes Hdw. Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Philip Emge</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sophia Stemmer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-08-2699</u> | | 17. INFORMANT <u>W. Wilbur Emge, Jr.</u> Address <u>Same As #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 420.1 DUE TO (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>with cardiac decompensation</u> 5 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>November 15, 1951</u> , to <u>Dec. 11, 1957</u> , that I last saw the deceased alive on <u>Dec. 10, 1957</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R.M. McLaughlin</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Mountain Road Pasadena Md. Dec 14, 1957</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec. 14, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Langston</u> ADDRESS <u>Glen Burnie, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 12 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>L. J. Adley</u> | |

BUREAU V. S.

DEC 12 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12637

12668 CERTIFICATE OF DEATH

Reg. Dist. No. 24

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The form copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

| | | | |
|---|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MAJOR CONV. HOME</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN STREET ADDRESS (If rural give location) <u>2805 Evergreen Ave.</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>DAVID</u> (First) <u>L.</u> (Middle) <u>ESPEY</u> (Last) | | 4. DATE OF DEATH <u>Dec 14</u> 19 <u>57</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Nov. 25, 1888</u> |
| 9. AGE last birthday <u>69</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KING OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto., Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Romeo Espy</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Ann Leyshon</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS <u>2805 Evergreen</u> <u>Mrs. Adelaide Stockinger</u> #14 | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>CARDIAC THROMBOSIS</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIOSCLEROSIS GENERAL</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 1955</u> to <u>Dec 14, 1957</u> , that I last saw the deceased alive on <u>Dec 11, 1957</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>Joseph V. Alet</u> | | DATE SIGNED <u>12-14-57</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>12/17/57 Mt. Carmel Cem.</u> | | LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>Dec 14 57</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Rich 5305 Harford</u> | |

CERTIFICATE OF DEATH

1. UNDER REGISTRATION DISTRICT OF BALTIMORE

2. PLACE OF DEATH

3. NAME OF DECEASED
4. SEX
5. AGE
6. OCCUPATION
7. MARITAL STATUS
8. DATE OF BIRTH
9. DATE OF DEATH
10. PLACE OF BIRTH
11. PLACE OF DEATH
12. CAUSE OF DEATH
13. MANNER OF DEATH
14. SIGNATURE OF REGISTRAR
15. SIGNATURE OF DECEASED
16. SIGNATURE OF WITNESSES
17. SIGNATURE OF MEDICAL EXAMINER
18. SIGNATURE OF CLERGYMAN
19. SIGNATURE OF BURIAL OFFICIAL
20. SIGNATURE OF OTHER OFFICIALS

21. DATE OF DEATH
22. TIME OF DEATH
23. PLACE OF DEATH
24. PLACE OF BIRTH
25. PLACE OF DEATH
26. CAUSE OF DEATH
27. MANNER OF DEATH
28. SIGNATURE OF REGISTRAR
29. SIGNATURE OF DECEASED
30. SIGNATURE OF WITNESSES
31. SIGNATURE OF MEDICAL EXAMINER
32. SIGNATURE OF CLERGYMAN
33. SIGNATURE OF BURIAL OFFICIAL
34. SIGNATURE OF OTHER OFFICIALS

35. DATE OF DEATH
36. TIME OF DEATH
37. PLACE OF DEATH
38. PLACE OF BIRTH
39. PLACE OF DEATH
40. CAUSE OF DEATH
41. MANNER OF DEATH
42. SIGNATURE OF REGISTRAR
43. SIGNATURE OF DECEASED
44. SIGNATURE OF WITNESSES
45. SIGNATURE OF MEDICAL EXAMINER
46. SIGNATURE OF CLERGYMAN
47. SIGNATURE OF BURIAL OFFICIAL
48. SIGNATURE OF OTHER OFFICIALS

49. DATE OF DEATH
50. TIME OF DEATH
51. PLACE OF DEATH
52. PLACE OF BIRTH
53. PLACE OF DEATH
54. CAUSE OF DEATH
55. MANNER OF DEATH
56. SIGNATURE OF REGISTRAR
57. SIGNATURE OF DECEASED
58. SIGNATURE OF WITNESSES
59. SIGNATURE OF MEDICAL EXAMINER
60. SIGNATURE OF CLERGYMAN
61. SIGNATURE OF BURIAL OFFICIAL
62. SIGNATURE OF OTHER OFFICIALS

63. DATE OF DEATH
64. TIME OF DEATH
65. PLACE OF DEATH
66. PLACE OF BIRTH
67. PLACE OF DEATH
68. CAUSE OF DEATH
69. MANNER OF DEATH
70. SIGNATURE OF REGISTRAR
71. SIGNATURE OF DECEASED
72. SIGNATURE OF WITNESSES
73. SIGNATURE OF MEDICAL EXAMINER
74. SIGNATURE OF CLERGYMAN
75. SIGNATURE OF BURIAL OFFICIAL
76. SIGNATURE OF OTHER OFFICIALS

77. DATE OF DEATH
78. TIME OF DEATH
79. PLACE OF DEATH
80. PLACE OF BIRTH
81. PLACE OF DEATH
82. CAUSE OF DEATH
83. MANNER OF DEATH
84. SIGNATURE OF REGISTRAR
85. SIGNATURE OF DECEASED
86. SIGNATURE OF WITNESSES
87. SIGNATURE OF MEDICAL EXAMINER
88. SIGNATURE OF CLERGYMAN
89. SIGNATURE OF BURIAL OFFICIAL
90. SIGNATURE OF OTHER OFFICIALS

91. DATE OF DEATH
92. TIME OF DEATH
93. PLACE OF DEATH
94. PLACE OF BIRTH
95. PLACE OF DEATH
96. CAUSE OF DEATH
97. MANNER OF DEATH
98. SIGNATURE OF REGISTRAR
99. SIGNATURE OF DECEASED
100. SIGNATURE OF WITNESSES
101. SIGNATURE OF MEDICAL EXAMINER
102. SIGNATURE OF CLERGYMAN
103. SIGNATURE OF BURIAL OFFICIAL
104. SIGNATURE OF OTHER OFFICIALS

105. DATE OF DEATH
106. TIME OF DEATH
107. PLACE OF DEATH
108. PLACE OF BIRTH
109. PLACE OF DEATH
110. CAUSE OF DEATH
111. MANNER OF DEATH
112. SIGNATURE OF REGISTRAR
113. SIGNATURE OF DECEASED
114. SIGNATURE OF WITNESSES
115. SIGNATURE OF MEDICAL EXAMINER
116. SIGNATURE OF CLERGYMAN
117. SIGNATURE OF BURIAL OFFICIAL
118. SIGNATURE OF OTHER OFFICIALS

119. DATE OF DEATH
120. TIME OF DEATH
121. PLACE OF DEATH
122. PLACE OF BIRTH
123. PLACE OF DEATH
124. CAUSE OF DEATH
125. MANNER OF DEATH
126. SIGNATURE OF REGISTRAR
127. SIGNATURE OF DECEASED
128. SIGNATURE OF WITNESSES
129. SIGNATURE OF MEDICAL EXAMINER
130. SIGNATURE OF CLERGYMAN
131. SIGNATURE OF BURIAL OFFICIAL
132. SIGNATURE OF OTHER OFFICIALS

133. DATE OF DEATH
134. TIME OF DEATH
135. PLACE OF DEATH
136. PLACE OF BIRTH
137. PLACE OF DEATH
138. CAUSE OF DEATH
139. MANNER OF DEATH
140. SIGNATURE OF REGISTRAR
141. SIGNATURE OF DECEASED
142. SIGNATURE OF WITNESSES
143. SIGNATURE OF MEDICAL EXAMINER
144. SIGNATURE OF CLERGYMAN
145. SIGNATURE OF BURIAL OFFICIAL
146. SIGNATURE OF OTHER OFFICIALS

147. DATE OF DEATH
148. TIME OF DEATH
149. PLACE OF DEATH
150. PLACE OF BIRTH
151. PLACE OF DEATH
152. CAUSE OF DEATH
153. MANNER OF DEATH
154. SIGNATURE OF REGISTRAR
155. SIGNATURE OF DECEASED
156. SIGNATURE OF WITNESSES
157. SIGNATURE OF MEDICAL EXAMINER
158. SIGNATURE OF CLERGYMAN
159. SIGNATURE OF BURIAL OFFICIAL
160. SIGNATURE OF OTHER OFFICIALS

161. DATE OF DEATH
162. TIME OF DEATH
163. PLACE OF DEATH
164. PLACE OF BIRTH
165. PLACE OF DEATH
166. CAUSE OF DEATH
167. MANNER OF DEATH
168. SIGNATURE OF REGISTRAR
169. SIGNATURE OF DECEASED
170. SIGNATURE OF WITNESSES
171. SIGNATURE OF MEDICAL EXAMINER
172. SIGNATURE OF CLERGYMAN
173. SIGNATURE OF BURIAL OFFICIAL
174. SIGNATURE OF OTHER OFFICIALS

175. DATE OF DEATH
176. TIME OF DEATH
177. PLACE OF DEATH
178. PLACE OF BIRTH
179. PLACE OF DEATH
180. CAUSE OF DEATH
181. MANNER OF DEATH
182. SIGNATURE OF REGISTRAR
183. SIGNATURE OF DECEASED
184. SIGNATURE OF WITNESSES
185. SIGNATURE OF MEDICAL EXAMINER
186. SIGNATURE OF CLERGYMAN
187. SIGNATURE OF BURIAL OFFICIAL
188. SIGNATURE OF OTHER OFFICIALS

189. DATE OF DEATH
190. TIME OF DEATH
191. PLACE OF DEATH
192. PLACE OF BIRTH
193. PLACE OF DEATH
194. CAUSE OF DEATH
195. MANNER OF DEATH
196. SIGNATURE OF REGISTRAR
197. SIGNATURE OF DECEASED
198. SIGNATURE OF WITNESSES
199. SIGNATURE OF MEDICAL EXAMINER
200. SIGNATURE OF CLERGYMAN
201. SIGNATURE OF BURIAL OFFICIAL
202. SIGNATURE OF OTHER OFFICIALS

203. DATE OF DEATH
204. TIME OF DEATH
205. PLACE OF DEATH
206. PLACE OF BIRTH
207. PLACE OF DEATH
208. CAUSE OF DEATH
209. MANNER OF DEATH
210. SIGNATURE OF REGISTRAR
211. SIGNATURE OF DECEASED
212. SIGNATURE OF WITNESSES
213. SIGNATURE OF MEDICAL EXAMINER
214. SIGNATURE OF CLERGYMAN
215. SIGNATURE OF BURIAL OFFICIAL
216. SIGNATURE OF OTHER OFFICIALS

BUREAU V. S.

DEC 20 1957

RECEIVED

RECEIVED

12669

CERTIFICATE OF DEATH

Reg. Dist. No.

12638

27

| | | | | | | | |
|--|----------------------------------|---|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Portage | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup, Md. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS Box 117 | | | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle R Last Farrell, Jr | | | | 4. DATE OF DEATH Month December Day 17 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 13 December 1934 | | 9. AGE (In years last birthday) 23 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Army | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | |
| 13. FATHER'S NAME Joseph R. Farrell, Sr. | | | | 14. MOTHER'S MAIDEN NAME Unknown (Deceased) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Personnel Records, Fort George G. Meade, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal injuries, two compound fractures, right lower leg DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Immediate |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 0445 am Dec 18 19 57 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 175, Md | | 20f. (City or town) (County) (State) Jessup Anne Arundel Md. | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive Dead on arrival , and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Army Hospital, Fort George G Meade, Md. DATE SIGNED 17 Dec 1957 | | | | | | | |
| ACTUAL SIGNATURE John L. Robertson | | PHYSICIAN'S NAME (Type) JOHN L. ROBERTSON, Capt. MC | | | | | |
| 22a. TIME OF REMOVAL (Specify) | | 22b. DATE THEREOF 12-19-1957 | | 22c. NAME OF CEMETERY OR CREMATORY S.O. Bissler Funeral Home | | 22d. LOCATION (City, town, or county) (State) Kent, Ohio | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Wolverton Funeral Home, Inc | | | | 24a. REC'D BY REGISTRAR DATE 17 Dec 57 | | 24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSG | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 23 1957

RECEIVED

12635 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u> | | | | d. STREET ADDRESS <u>1146 MONTICELLO</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>ORPHA FOSSETT FELDMeyer</u> | | | | 4. DATE OF DEATH <u>DECEMBER 16 1957</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>OCT. 28, 1889</u> | |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME <u>GEORGE SANNER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MAE FOSSETT</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <u>MRS. L. N. JEFFERSON</u> | | | | 17. ADDRESS <u>141 Spr. View Ave., Annapolis, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PLEURAL EFFUSION</u> DUE TO (c) <u>METASTATIC CARCINOMA RIGHT BREAST</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Nov. 26, 1957</u> to <u>Dec. 16, 1957</u> , that I last saw the deceased alive on <u>Dec. 16, 1957</u> , and that death occurred at <u>2:35 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Jesse L. Wilkins</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>98 Cathedral St., Annapolis, Md.</u> | | | |
| DATE SIGNED <u>12/16/57</u> | | | | DATE SIGNED <u>12/17/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JESSE L. WILKINS M.D.</u> | | | | ADDRESS <u>Annapolis, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-19-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cent</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Slayton Sons</u> | | | | ADDRESS <u>Annapolis Md.</u> | | | |
| 24a. REC'D BY REGISTRAR <u>12/17/57</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12670

CERTIFICATE OF DEATH

12640

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AAH</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Water Oak Pt.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Water Oak Pt.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>C.</u> Last <u>Fleischmann</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 1 - 1895</u> | 9. AGE (In years last birthday) <u>62</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Mach.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Chem. Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u> </u> | |
| 13. FATHER'S NAME <u>Oscar Fleischmann</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eliz. Schenniger</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>WWI</u> | | 17. INFORMANT <u>Family</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>1 year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> | | | | 20g. (County) <u> </u> | | 20h. (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>57</u> , to <u>12/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>57</u> , and that death occurred at <u>1:00 A.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. Brady Smith</u> | | | | ADDRESS (Street, city or town, state) <u>Riviera Beach Md.</u> | | DATE SIGNED <u>12/14/57</u> | |
| PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u> | | | | <u>RIVIERA BEACH MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-17-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Meadowdale Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u> | | | | ADDRESS <u>130 E. Fort Me.</u> | | 24a. REC'D BY REGISTRAR <u> </u> | |
| 24b. REGISTRAR'S SIGNATURE <u> </u> | | | | DATE <u>DEC 17 1957</u> | | 24c. REGISTRAR'S SIGNATURE <u> </u> | |

BUREAU A. S.

DEC 17 1957

RECEIVED

Item 20 Film 223 12671
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Item 1-Film 223-12/18/57-b
 12641
 Reg. Dist. No.

1. PLACE OF DEATH
 o. COUNTY **ANNE ARUNDEL**
 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Annapolis**
 c. LENGTH OF STAY IN 1b
 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **RT. #14**
 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission)
 o. STATE **Md.**
 b. COUNTY **HARVARD**
 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **BALTIMORE UPPER MALLBORO**
 d. STREET ADDRESS **RT. 16X0.2**
 e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)
 First **JOSEPH** Middle **A** Last **FLETCHER**
 4. DATE OF DEATH
 Month **12** Day **4** Year **1957**
 5. SEX **MALE**
 6. COLOR OR RACE **COLORED**
 7. MARRIED ☒ NEVER MARRIED ☐
 8. DATE OF BIRTH **AUG. 13, 1911**
 9. AGE (In years last birthday) **46** yrs.
 IF UNDER 1 YEAR
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **FARMER**
 10b. KIND OF BUSINESS OR INDUSTRY **FARM**
 11. BIRTHPLACE (State or foreign country) **MARYLAND**
 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**
 13. FATHER'S NAME **JAMES FLETCHER**
 14. MOTHER'S MAIDEN NAME **MARY C. PERRY**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
 16. SOCIAL SECURITY NO.
 17. INFORMANT **MRS. MARY C. FLETCHER-UPPER MALLBORO**
 Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **MULTIPLE TRAUMATIC INJURIES**
 812X DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
 (b)
 DUE TO
 (c)
 INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Apparently struck by auto**
 20c. TIME OF INJURY Month, Day, Year
 Hour **12/4/57** 19
 20d. INJURY OCCURRED While at work ☐ Not while at work ☒
 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Highway**
 20f. (City or town) (County) (State)
nr. Davidsonville A.A. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐
 ACTUAL SIGNATURE **Paul F. Guerin** M.D. CHIEF MEDICAL EXAMINER ☐
 EXAMINER'S NAME (Type) **PAUL F. GUERIN** ASSISTANT MEDICAL EXAMINER ☒
 DEPUTY MEDICAL EXAMINER ☐
 DATE SIGNED **12-7-57**

22a. BURIAL CREMATION, REMOVAL (Specify) **BURIAL**
 22b. DATE THEREOF **12.13.57**
 22c. NAME OF CEMETERY OR CREMATORY **Arlington Nat'l Cemetery Arlington, Va.**
 22d. LOCATION (City, town, or county) (State)
 23. FUNERAL DIRECTOR'S SIGNATURE **HOLLAND FUNERAL HOME-1631 DRUID HILL AVE.**
 24a. REC'D BY REGISTRAR **DEC 12 57**
 24b. REGISTRAR'S SIGNATURE **W. L. Leach**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WHITE HUNGAR

JOSEPH H FLETCHER 05 4 25

MULTIPLE TRAUMATIC INJURIES

PAUL F. GERRIT
Paul F. Gerrit

X

X

BUREAU V. S.

DEC 12 1957

RECEIVED

, 12636

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA Anne Arundel General Hospital | | | | d. STREET ADDRESS 30 Monroe Court | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ELMER Middle AUSTIN Last FORD | | | | 4. DATE OF DEATH Month DEC. Day 23 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH AUG 22, 1882 | |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman | | 10b. KIND OF BUSINESS OR INDUSTRY State of Md. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George W. Ford | | | | 14. MOTHER'S MAIDEN NAME Priscilla | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 214-05-0376 | | 17. INFORMANT Mollie Jane Ford | | Address Wife same as # 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 HOUR UNKNOWN | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from APRIL , 19 67 , to 23 DEC , 19 57 , that I last saw the deceased alive on 23 DEC , 19 57 , and that death occurred at 6:00 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edward S. Beck M.D. | | | | ADDRESS (Street, city or town, state) 41 Southgate Ave Annapolis, Md. | | | |
| PHYSICIAN'S NAME (Type) Edward S. Beck | | | | DATE SIGNED 41 Southgate Ave Annapolis, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-26-57 | | 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemet | | 22d. LOCATION (City, town, or county) (State) Annapolis, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home | | | | ADDRESS Annapolis, Md. | | 24a. REC'D BY REGISTRAR DEC 30 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Ann J. Cheney | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 4

RECEIVED

JUN 30 1967

BUREAU V. 1

1957 08 02

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND-STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12672 CERTIFICATE OF DEATH

12643

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u> | | c. LENGTH OF STAY IN 1b <u>2yrs. 3mos. 27ds.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u> | | d. STREET ADDRESS <u>1006 N. Central Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Francis</u> Last <u>Francis</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/5/80</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Candy Factory Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u> | |
| 13. FATHER'S NAME <u>James Snyder</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Hospital Record</u> | |
| 17. INFORMANT <u>Hospital Record</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease and Senility</u> DUE TO (c) <u>Gangrene of left foot, Ca. of Cervix?</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Senile Arteriosclerosis</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August 16</u> , 19 <u>57</u> , to <u>December 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 12</u> , 19 <u>57</u> , and that death occurred at <u>12:30AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> | | ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u> | |
| PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp</u> | | DATE SIGNED <u>12/12/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u> | | 22b. DATE THEREOF <u> </u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Crownsville Hosp</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hospital disposal</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |
| DATE <u> </u> | | | |

RECEIVED

12637 CERTIFICATE OF DEATH

12644

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Crispe Anndel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D.C.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>115 Clay St.</u> | | | | d. STREET ADDRESS <u>115 Clay St.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>William</u> Middle <u>William</u> Last | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-30-1895</u> | |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. Family</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>John J. McSwans</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Hammond</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>170</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>200-18-6506</u> | | | |
| 17. INFORMANT <u>Stattie McThearson</u> Address <u>Anna, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterus</u> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>November 16, 1957</u> to <u>Dec 6, 1957</u> , that I last saw the deceased alive on <u>Dec 6, 1957</u> , and that death occurred at <u>1254 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R. R. Richardson</u> | | | | ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u> DATE SIGNED <u>12/8/57</u> | | | |
| PHYSICIAN'S NAME (Type) _____ | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-9-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beech</u> ADDRESS <u>108 W. 1st St. Annapolis, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>Mr. J. French</u> | | 24b. REGISTRAR'S SIGNATURE | |
| DATE <u>12/9/57</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12646
74

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | |
|--|-------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> | | c. LENGTH OF STAY IN 1b <u>Few seconds</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Severna Park</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McKinsey Road and Route 2</u> | | | d. STREET ADDRESS <u>McKinsey Road.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Harry Chester Goudy, Sr.</u> | | | 4. DATE OF DEATH Month <u>December</u> Day <u>9th</u> Year <u>1957</u> | | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/17/10</u> | | 9. AGE (In years last birthday) <u>47</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney at Law.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME <u>Harry Chester Goudy</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mina Klaesius</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes. Navy 1942-45</u> | | 16. SOCIAL SECURITY NO. <u>160-05-9222</u> | 17. INFORMANT <u>Harry Chester Goudy (son)</u> Address <u>Severna Park, Md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>816x</u> IMMEDIATE CAUSE (a) <u>Crushed chest. Brain injury. Laceration of right buttock.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(mobile.)</u> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was driving across route 2 and another vehicle hit his auto-</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>10.35 a.m. 12/9/57 19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 2</u> | | 20f. (City or town) (County) (State) <u>Severna Park, A.A. Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/10/57</u> | | |
| 22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/12/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balto. 17, Md.</u> | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 13 1957</u> | | |
| | | | 24b. REGISTRAR'S SIGNATURE <u>T. J. Dealy</u> | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12638

CERTIFICATE OF DEATH

Reg. Dist. No.

12647

| | | | |
|---|-----------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hospital</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Barbara</u> First <u>Ann</u> Middle <u>Gross</u> Last | | 4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-10-1957</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9b. KIND OF BUSINESS OR INDUSTRY | |
| 10a. BIRTHPLACE (State or foreign country) <u>Harwood Md.</u> | | 10b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 11. FATHER'S NAME <u>Albert Gross</u> | | 12. MOTHER'S MAIDEN NAME <u>Josephine Creek</u> | |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 14. SOCIAL SECURITY NO. <u>Albert Gross</u> | |
| 15. ADDRESS <u>Harwood Md.</u> | | 16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Convulsion, Dehydration, Hypoxia</u> 475x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute upper respiratory infection</u> DUE TO (c) <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 17. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>12-16-57</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12-16-57</u> , 19 <u>12-17-57</u> , that I last saw the deceased alive on <u>12-17-57</u> , 19 <u>12-17-57</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A.T. Allen</u> M.D. | | ADDRESS <u>St. Catherine</u> DATE SIGNED <u>12-18-57</u> | |
| PHYSICIAN'S NAME (Type) <u>A T ALLEN</u> | | <u>Ann Gross</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-19-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Adams Chapel</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bayard, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR <u>12/26/57</u> | |
| ADDRESS <u>2063191XV4</u> | | 24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u> | |

DEC 27 1967

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12645

12639

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|--|------------------------------|--|----------------------------------|--|---|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>Maryland</u> COUNTY <u>A. A.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shadeside</u> | | TOWN <u>Shadeside</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | LENGTH OF STAY (In this place) | | STREET ADDRESS (If rural give location) | | ADDRESS | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hosp.</u> | | | | STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Clark O. Gross</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>12 31 1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Mar.</u> | 8. DATE OF BIRTH <u>3-1-1880</u> | 9. AGE last birthday <u>77</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cyberman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | | 11. BIRTHPLACE (State or foreign country) <u>Chatham, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Gross</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Coates</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-18-5110</u> | | 17. INFORMANT'S ADDRESS <u>James Gross - Anna, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 332X IMMEDIATE CAUSE (A) <u>Acute Broncho-Pneumonia</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO <u>Encephalomalacia of the</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Left Hemisphere of the</u> | | | | | | | |
| STATING UNDERLYING CAUSE LAST. (C) <u>Brain</u> | | | | | | <u>12-14-57</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>12/17/57</u> , to <u>12/31/57</u> , that I last saw the deceased alive on <u>12/31/57</u> , 19 <u>57</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W. R. Ketchum</u> | | M.D. <u>110 - CHAY ST ANNAPOLIS, MD 11/1/58</u> | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-2-58</u> | | NAME OF CEMETERY OR CREMATORY <u>Gross</u> | | LOCATION (City, town, or county) (State) <u>Shadeside, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Wm. French</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>William Guse, Jr. Anna, Md.</u> | | ADDRESS | |
| DATE <u>1/6/58</u> | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G223 12-24-57 et

12648

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Severna Park</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 3V01-4</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2 (Earleigh Heights)</u> | | | | d. STREET ADDRESS <u>737 LENNOX ST</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>RACHEL</u> Middle <u>LEE</u> Last <u>HEMBREE</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | |
| 8. DATE OF BIRTH <u>17 MAY 1923</u> | | 9. AGE (In years last birthday) <u>34</u> yrs. | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>TENN</u> | | | |
| 13. FATHER'S NAME <u>AARON BAIRD</u> | | | | 14. MOTHER'S MAIDEN NAME <u>VINNIA HALL</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>408-30-7308</u> | | 17. INFORMANT <u>Hubert Baird</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, right humerus, right femur</u> DUE TO (b) <u>Comm. fracture of right leg 3 inches above ankle</u> DUE TO (c) <u>Multiple lacerations scattered over body</u> Sudden | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was hit by an automobile while walking on the highway</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>12/7 1957</u> Hour <u>11:30</u> a.m. <u> </u> m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 2</u> | | | |
| 20f. (City or town) <u>Severna Park, A.A.</u> | | (County) <u>Md.</u> | | (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>12/9/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>18 DEC 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN CEM</u> | | | |
| 22d. LOCATION (City, town, or county) <u>A.A. Co Md</u> | | (State) | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. B. M. Walters</u> | | ADDRESS <u>RAH & Stricker</u> | | 24. REG'D BY REGISTRAR <u>DEC 19 1957</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>L. J. Adkins</u> | | DATE | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---------------------|--|---------------------|--|---------------------|--|---------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES EARL RAY | | 35 | | M | | W | | 12-1-67 | | MEMPHIS, TENN. | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | CAUSE OF DEATH | | MANNER OF DEATH | |
| ATTORNEY | | HIGH SCHOOL | | MARRIED | | METHODIST | | HEART DISEASE | | SUICIDE | |
| FATHER'S NAME | | MOTHER'S NAME | | BIRTH DATE | | BIRTH PLACE | | EDUCATION | | OCCUPATION | |
| JAMES EARL RAY | | MAURINE E. RAY | | 12-1-32 | | MEMPHIS, TENN. | | HIGH SCHOOL | | ATTORNEY | |
| FATHER'S OCCUPATION | | MOTHER'S OCCUPATION | | FATHER'S BIRTH DATE | | MOTHER'S BIRTH DATE | | FATHER'S BIRTH PLACE | | MOTHER'S BIRTH PLACE | |
| FATHER'S OCCUPATION | | MOTHER'S OCCUPATION | | FATHER'S BIRTH DATE | | MOTHER'S BIRTH DATE | | FATHER'S BIRTH PLACE | | MOTHER'S BIRTH PLACE | |

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BUREAU V. 3

DEC 19 1967

RECEIVED

12676

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Linthicum Heits A A Co MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Linthicum Heights A A Co Md b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same | | | | c. LENGTH OF STAY IN 1b 7Yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 439 Cleveland Rd Linthicum Heights | | | | d. STREET ADDRESS 439 Cleveland Rd A A Co Md | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Walter Ray Hoffman | | | | 4. DATE OF DEATH Month Day Year 12-8-1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-16-1911 ? | |
| 9. AGE (In years last birthday) 46 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Md State Police | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto City Md | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | | | |
| 13. FATHER'S NAME Philiph Hoffman | | | | 14. MOTHER'S MAIDEN NAME Rosa Connelly | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-03-3578 | | 17. INFORMANT Address Audery Hoffman 439 Cleveland Rd Linthicum A A Co Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Nov 2, 1957 , to Dec 8, 1957 , that I last saw the deceased alive on Dec 2, 1957 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE C. Milton Linthicum | | | | ADDRESS (Street, city or town, state) DATE SIGNED 106 W. Maple Rd Linthicum Heights Md. 12/9/57 | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-11-57 | | 22c. NAME OF CEMETERY OR CREMATORY Woodland Cem | | 22d. LOCATION (City, town, or county) (State) Woodland Balto Co Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward Toulson | | | | 24a. REC'D BY REGISTRAR DEC 10 '57 | | 24b. REGISTRAR'S SIGNATURE Alf Leach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | | 4. DATE OF BIRTH May 19, 1932 | | 5. PLACE OF BIRTH Jackson, Mississippi | |
| 6. OCCUPATION Attorney | | 7. MARITAL STATUS Single | | 8. COLOR White | | 9. HEIGHT 5' 10" | | 10. WEIGHT 175 | |
| 11. EDUCATION High School Graduate | | 12. RELIGION Methodist | | 13. SOCIAL SECURITY NUMBER [REDACTED] | | 14. MOTHER'S MAIDEN NAME [REDACTED] | | 15. FATHER'S NAME [REDACTED] | |
| 16. DATE OF DEATH June 4, 1968 | | 17. TIME OF DEATH 10:00 AM | | 18. PLACE OF DEATH Memphis, Tennessee | | 19. CAUSE OF DEATH [REDACTED] | | 20. MANNER OF DEATH Homicide | |
| 21. SIGNATURE OF DECEASED [REDACTED] | | 22. SIGNATURE OF NEXT OF KIN [REDACTED] | | 23. SIGNATURE OF PHYSICIAN [REDACTED] | | 24. SIGNATURE OF CORONER [REDACTED] | | 25. SIGNATURE OF REGISTRAR [REDACTED] | |

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DEC 10 1957
BUREAU V. 5

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12650

12640

CERTIFICATE OF DEATH

Reg. Dist. No.

21

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. LENGTH OF STAY IN 1b 7 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Admiral Apts.-219 Hanover St. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MILDRED Middle HARRISON Last HOLLIS | | | | 4. DATE OF DEATH Month DECEMBER Day 30 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> XXXXXXXXXX | | 8. DATE OF BIRTH Feb. 28-1891 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Bulk Ice Cream Plant | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Luther F. Harrison | | | | 14. MOTHER'S MAIDEN NAME May Moberly | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-10-3190 | | 17. INFORMANT Edgar H. Hollis- Admiral Apts.219 Hanover St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 153x DUE TO (b) PHLEBOTROMBOSIS (LEG VEINS) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) CARCINOMA OF COLON PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH 30 MIN. 1 MONTH 1 YEAR | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MAY , 1957, to DEC. 30 , 1957, that I last saw the deceased alive on DEC. 30 , 1957, and that death occurred at 11:15 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John A. Hedeman | | | | ADDRESS (Street, city or town, state) 68 Franklin St. Annapolis, Md. | | DATE SIGNED 12/30/57 | |
| PHYSICIAN'S NAME (Type) Dr. John A. Hedeman | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-2-1958 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son | | | | ADDRESS Frederick-Maryland | | 24a. REC'D BY REGISTRAR JAN 3 1958 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mr. French | | | |

CERTIFICATE OF DEATH

Form No. 1

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| <p>1. Name of deceased John A. Smith</p> | | <p>2. Sex Male</p> | | <p>3. Race White</p> | | <p>4. Date of birth Jan. 1, 1900</p> | | <p>5. Date of death Jan. 3, 1950</p> | |
| <p>6. Usual residence 123 Main St., Baltimore, Md.</p> | | <p>7. Place of death Home</p> | | <p>8. Cause of death Heart disease</p> | | <p>9. Duration of illness 2 weeks</p> | | <p>10. Signature of physician J. H. Jones, M.D.</p> | |
| <p>11. Name of informant John A. Smith</p> | | <p>12. Relationship to deceased Son</p> | | <p>13. Signature of informant John A. Smith</p> | | <p>14. Date of completion of certificate Jan. 3, 1950</p> | | <p>15. Signature of registrar J. H. Jones, M.D.</p> | |

BUREAU V. 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12677 CERTIFICATE OF DEATH

Reg. Dist. No. 12651 38

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u> | | c. LENGTH OF STAY IN 1b <u>13 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | d. STREET ADDRESS <u>1103 Division Street</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Holloway</u> Last <u>Holloway</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>19 57</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/14/1886</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Spencer Rawlings</u> | | 14. MOTHER'S MAIDEN NAME <u>Lucinda</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT <u>Hospital Records</u> | | Address _____ | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.S.H.C.V.D.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ p. m. _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) (County) (State) _____ | |
| 21. I certify that I attended the deceased from <u>December 3, 19 57</u> , to <u>December 16, 19 57</u> , that I last saw the deceased alive on <u>December 16, 19 57</u> , and that death occurred at <u>8:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>12/17/57</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> <u>Crownsville State Hospital, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-20-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frances A. Hemsley</u> ADDRESS <u>578 W. Biddle St.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 20 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>St. M. Joyce</u> | | | |

RECEIVED

2nd Reg 1/3/15
place 1/17

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
|--|--|--------------------------------|--|--|--|---|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 12641 | | | | | | | | | | | |
| Reg. Dist. No. 12652 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>A. A.</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. LENGTH OF STAY IN 1b <u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>1950 Forest Drive</u> | | | | | | d. STREET ADDRESS <u>1950 Forest Drive</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Denise Howard</u> | | | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1957</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-30-57</u> | | 9. AGE (In years last birthday) <u>2 mo 2</u> | | IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | | 11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Daniel M. Howard</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Bernice D. Wallace</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT <u>Daniel M. Howard - Anna, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 9240 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Blanket over face - Infant had been coughing early this A.M.</u> (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVIEW BETWEEN ONSET AND DEATH <u>Shaken</u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Checked by mother at 9 A.M. -- blanket over face.</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>9:00 a.m. 12-26-57</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>A A</u> | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>William Reese, Jr.</u> | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>W. Reese, Jr.</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>12-30-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u> | | 22d. LOCATION (City, town, or county) <u>Annapolis, Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Anna, Md.</u> | | | | | | 24a. REC'D BY REGISTRAR DATE <u>12/30/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Wm. J. Church</u> | | | |

2063193XV5

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 31 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12653

Reg. Dist. No.

12642

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Ce A</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>U. S. General Hospt.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Henry</i> Last <i>Hubbard</i> | | 4. DATE OF DEATH Month <i>DEC</i> Day <i>3</i> Year <i>1957</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1-23-1888</i> |
| 9. AGE (In years last birthday) <i>69</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boat Marina</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Yacht Business</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Alonso Hubbard</i> | | 14. MOTHER'S MAIDEN NAME <i>Elinabeth Freeman</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Mrs Mary Hubbard</i> | | Address <i>(2)</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHOPNEUMONIA</i> <i>148X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>CARCINOMA OF PHARYNX</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| INTERVAL BETWEEN ONSET AND DEATH <i>1 WEEK</i> <i>18 MOS</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Jan 2</i> , 19 <i>57</i> , to <i>Dec 3</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Dec 2</i> , 19 <i>57</i> , and that death occurred at <i>7:40</i> A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>John L. Korman</i> M.D. <i>12/3/57</i> | | | |
| ACTUAL SIGNATURE <i>John L. Korman</i> | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <i>Burial</i> | <i>12-6-57</i> | <i>Cedar Bluff Cent</i> | <i>Annapolis Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Scyle Soos</i> | | ADDRESS <i>Annapolis Md</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>12/4/57</i> | | 24b. REGISTRAR'S SIGNATURE <i>J. J. Russell</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

12678 CERTIFICATE OF DEATH

1265424

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie RFD - Point Pleasant</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Glen Burnie RFD - Point Pleasant</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>42-30-245A - Marley Creek Drive</u> | | | | d. STREET ADDRESS <u>Box 245A RT-2 - Marley Creek Drive</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edward Ittner</u> | | | | 4. DATE OF DEATH Month Day Year <u>December 20 1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>DEC-18, 1887</u> | |
| 9. AGE (In years lost birthday) <u>70</u> | | IF UNDER 1 YEAR Months Days Hours Min. <u>70</u> | | IF UNDER 24 HRS. <u>70</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber (ret.)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>GANLEY Plumbers</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 13. FATHER'S NAME <u>John Ittner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Amelia Beinslow</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>11111</u> | | | | 16. SOCIAL SECURITY NO. <u>217-01-3795</u> | | 17. INFORMANT Address <u>Mrs. Wilhelmina Ittner Same as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Cerebral Hemorrhage</u> DUE TO (b) <u>Diabetes - Mellitus</u> DUE TO (c) <u>Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>15 years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Jan 1, 1938</u> , to <u>Dec 20, 1957</u> , that I last saw the deceased alive on <u>12/20, 1957</u> , and that death occurred at <u>440</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Louis J. Glass</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>321 Baltimore Ave Baltimore</u> DATE SIGNED <u>12/21/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Louis J. Glass M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec 23, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Bunting</u> ADDRESS <u>Glen Burnie, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 24 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>L. J. Glass</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 21 1957

RECEIVED

12643 CERTIFICATE OF DEATH

Reg. Dist. 12655

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>D.A. County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>D.A. County</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownwood</u> | | | | c. LENGTH OF STAY IN 1b <u>Brownwood x2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Balsenal Hospital</u> | | | | d. STREET ADDRESS <u>1</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Baby Boy Johnson</u> | | | | 4. DATE OF DEATH <u>12-18-1957</u> 19 <u>19</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-18-1957</u> | |
| 9. AGE (In years last birthday) <u>2</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>17</u> Days <u>05</u> | | 11. IF UNDER 24 HRS. Hours <u>05</u> Min. <u>05</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Osiah Johnson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaretta Carr</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>Margaretta Carr Brownwood Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>757.3</u> <u>Congenital uterine obstruction</u> DUE TO <u>resulting in malformation of</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>urinary tract</u> DUE TO (c) <u>—</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>12-11-57</u> , 19 <u>19</u> , to <u>12-11-57</u> , 19 <u>19</u> , that I last saw the deceased alive on <u>12-11-57</u> , 19 <u>19</u> , and that death occurred at <u>9:40</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>A. T. Allen</u> | | | | ADDRESS (Street, city or town, state) <u>Annapolis, Md</u> | | | |
| M.D. <u>12-11-57</u> | | | | DATE SIGNED <u>12-11-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A T ALLEN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-13-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck</u> | | 22d. LOCATION (City, town, or county) (State) <u>Seidmore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Case, Jr - Anna, Md.</u> | | | | ADDRESS <u>—</u> | | 24a. REC'D BY REGISTRAR DATE <u>12/18/57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>—</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063367XV4

BUREAU V. S.

DEC 19 1957

RECEIVED

1-81
J. A. [Signature]
T. A.

172-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G224 1-2-58 et

126568

12679

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u> | | c. LENGTH OF STAY IN 1b <u>6 yr. 10 mos.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | 3Y01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u> | | d. STREET ADDRESS <u>611 Sharp Street</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Johnson</u> Last <u>Johnson</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>September 5, 1923</u> |
| 9. AGE (In years last birthday) <u>34</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | 11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Jacob Wilkins</u> | | 14. MOTHER'S MAIDEN NAME <u>Lillian</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Record</u> | | Address <u>Crownsville State Hosp.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cystopyelitis</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Paresis</u> DUE TO (c) <u>Decubitus Ulcers. Old Lung Abscess?</u> | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>2/10/50</u> , 19 <u>57</u> , to <u>12/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 26</u> , 1957, and that death occurred at <u>1:20 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> | | ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>12/26/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> | | <u>Crownsville, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-30-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>MT. ALBURN</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Adolphus Hatastead</u> | | 24a. REC'D BY REGISTRAR <u>DEC 30 1957</u> | |
| ADDRESS <u>918 N. Hill St.</u> | | 24b. REGISTRAR'S SIGNATURE <u>A. M. Jeynes</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO. 11

RECEIVED
DEC 30 1957
BUREAU V. 5

1 AM BOMB

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12657

12680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

77

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. <u>County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u> | c. LENGTH OF STAY IN 1b <u>20 y.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harding and Brightwood Avenues</u> | | d. STREET ADDRESS <u>Same</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Edward W. Kaiss</u> First Middle Last | | 4. DATE OF DEATH Month <u>December</u> Day <u>7th.</u> Year <u>19 57</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/30/90</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired U.S. Army Major.</u> | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Ernest Kaiss</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Kohler</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWI</u> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Kenneth Daley (Step Son) Cambridge, Mass.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging himself with a manilla</u> <u>974X</u> DUE TO <u>1/2 inch rope tied around his neck and fastened to</u> Conditions, if any, which gave rise to immediate cause (b) <u>a floor joist.</u> (a), stating the underlying cause last. DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>As per 18 above specified.</u> | | 20c. TIME OF INJURY Month, Day, Year <u>11.15 a.m. 12/7/57 19</u> | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cellar at Home</u> | |
| 20f. (City or town) <u>Odenton</u> | | (County) <u>A.A.</u> (State) <u>Md.</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>12/8/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/11/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Church Ce.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Odenton, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen Burnie, Md.</u> | | 24. REC'D BY REGISTRAR <u>DEC 13 1957</u> | |
| 25. REGISTRAR'S SIGNATURE <u>Cara Aschupp</u> | | DATE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

RECEIVED
DEC 13 1957
BUREAU V. S.

| | | | | | |
|-----------------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF MEDICAL EXAMINER | | 17. SIGNATURE OF JURY | | 18. SIGNATURE OF JURY | |
| 19. SIGNATURE OF JURY | | 20. SIGNATURE OF JURY | | 21. SIGNATURE OF JURY | |
| 22. SIGNATURE OF JURY | | 23. SIGNATURE OF JURY | | 24. SIGNATURE OF JURY | |
| 25. SIGNATURE OF JURY | | 26. SIGNATURE OF JURY | | 27. SIGNATURE OF JURY | |
| 28. SIGNATURE OF JURY | | 29. SIGNATURE OF JURY | | 30. SIGNATURE OF JURY | |
| 31. SIGNATURE OF JURY | | 32. SIGNATURE OF JURY | | 33. SIGNATURE OF JURY | |
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| 37. SIGNATURE OF JURY | | 38. SIGNATURE OF JURY | | 39. SIGNATURE OF JURY | |
| 40. SIGNATURE OF JURY | | 41. SIGNATURE OF JURY | | 42. SIGNATURE OF JURY | |
| 43. SIGNATURE OF JURY | | 44. SIGNATURE OF JURY | | 45. SIGNATURE OF JURY | |
| 46. SIGNATURE OF JURY | | 47. SIGNATURE OF JURY | | 48. SIGNATURE OF JURY | |
| 49. SIGNATURE OF JURY | | 50. SIGNATURE OF JURY | | 51. SIGNATURE OF JURY | |
| 52. SIGNATURE OF JURY | | 53. SIGNATURE OF JURY | | 54. SIGNATURE OF JURY | |
| 55. SIGNATURE OF JURY | | 56. SIGNATURE OF JURY | | 57. SIGNATURE OF JURY | |
| 58. SIGNATURE OF JURY | | 59. SIGNATURE OF JURY | | 60. SIGNATURE OF JURY | |
| 61. SIGNATURE OF JURY | | 62. SIGNATURE OF JURY | | 63. SIGNATURE OF JURY | |
| 64. SIGNATURE OF JURY | | 65. SIGNATURE OF JURY | | 66. SIGNATURE OF JURY | |
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| 70. SIGNATURE OF JURY | | 71. SIGNATURE OF JURY | | 72. SIGNATURE OF JURY | |
| 73. SIGNATURE OF JURY | | 74. SIGNATURE OF JURY | | 75. SIGNATURE OF JURY | |
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| 88. SIGNATURE OF JURY | | 89. SIGNATURE OF JURY | | 90. SIGNATURE OF JURY | |
| 91. SIGNATURE OF JURY | | 92. SIGNATURE OF JURY | | 93. SIGNATURE OF JURY | |
| 94. SIGNATURE OF JURY | | 95. SIGNATURE OF JURY | | 96. SIGNATURE OF JURY | |
| 97. SIGNATURE OF JURY | | 98. SIGNATURE OF JURY | | 99. SIGNATURE OF JURY | |
| 100. SIGNATURE OF JURY | | 101. SIGNATURE OF JURY | | 102. SIGNATURE OF JURY | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 20 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 12658 |
|---|--|---|--|--|---|--|---|---|---|----------------|
| 12681 | | | | | | | | | | Reg. Dist. No. |
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY AA | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. George G Meade Md | | | | | c. LENGTH OF STAY IN 1b 1 yr | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. ARMY HOSPITAL | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md | | | | | |
| | | | | | d. STREET ADDRESS 1229 Crawford Drive | | | | | |
| | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CLAUDIE SUE KIMBREL | | | | | 4. DATE OF DEATH Month Day Year DECEMBER 29 19 57 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 16 Mar 1953 | | 9. AGE (In years last birthday) yrs. 4 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Belleville Kansas | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME CLAUDE R KIMBREL | | | | | 14. MOTHER'S MAIDEN NAME (BLAIR) | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Address CLAUDE R KIMBREL, 1229 Crawford Drive Glen Burnie Md (Father) | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial injury, severe, type undetermined 795.5 DUE TO Unknown Cause Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Complete autopsy revealed hypoplasia of adrenal glands as only major finding with hyperplasia of lymph glands Fracture, simple, mandible, right 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at Officer Club Ft G G Meade Md 20c. TIME OF INJURY Month, Day, Year 1830 p. m. Dec 29 57 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Officers Club Ft G G Meade Md 20f. (City or town) (County) (State) Ft G G Meade Md | | | | | | | | | | |
| 21. I certify that I attended the deceased from 29 Dec , 19 57 , to 29 Dec , 19 57 , that I last saw the deceased alive on 29 Dec , 19 57 , and that death occurred at 1845 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 29 Dec 57 | | | | | | | | | | |
| ACTUAL SIGNATURE Myron Myers M.D. | | | | | DATE SIGNED 29 Dec 57 | | | | | |
| PHYSICIAN'S NAME (Type) MYRON MYERS, MD | | | | | USAH, FT. G. G. MEADE MD | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 2, 1958 St. Katherine's Ch. Cem. | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) Belleville, Kansas | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. J. Singleton | | | | | ADDRESS Glen Burnie, Md | | 24a. REC'D BY REGISTRAR 30 Dec 57 | | 24b. REGISTRAR'S SIGNATURE W. H. Downs, Jr. Capt. Med | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|---|--|---|--|------------------------|--|--------------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | 45 | | M | | W | | JAN 6 1958 | | BALTIMORE, MD | |
| MARRIAGE | | DATE OF BIRTH | | DATE OF DEATH | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | |
| MARRIED | | JAN 1 1913 | | JAN 6 1958 | | 10:00 AM | | HEART DISEASE | | NATURAL | |
| OCCUPATION | | EDUCATION | | RELIGION | | BIRTHPLACE | | CITY OF BIRTH | | STATE OF BIRTH | |
| LABORER | | 8 | | C | | MD | | BALTIMORE | | MD | |
| PREVIOUS ILLNESS | | HISTORY OF PRESENT ILLNESS | | TREATMENT | | POSTMORTEM EXAMINATION | | LABORATORY EXAMINATION | | OTHER INFORMATION | |
| NONE | | Sudden onset of chest pain, radiating to left arm, associated with sweating and nausea. | | Aspirin, morphine, and oxygen administered. | | None performed. | | None performed. | | None. | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF CLERK | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |

RECEIVED
JAN 6 1958
BUREAU V. S.

12659

21

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA MD.</u> | | c. LENGTH OF STAY IN 1b <u>30 YEARS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bar Harbor Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>GEORGE A</u> First Middle Last | | 4. DATE OF DEATH <u>DEC.</u> <u>4</u> <u>1957</u> Month Day Year | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>OCT 11, 1893</u> | |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u> | | 11b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u> | |
| 11c. BIRTHPLACE (State or foreign country) <u>BALTO, MD.</u> | | 11d. CITIZEN OF WHAT COUNTRY? <u>YES-USA</u> | |
| 12. FATHER'S NAME <u>CHARLES HENRY KRATSCH</u> | | 13. MOTHER'S MAIDEN NAME <u>LOUISE VOGEL</u> | |
| 14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 15. SOCIAL SECURITY NO. <u>UNKNOWN</u> | |
| 16. INFORMANT <u>WIFE</u> | | 17. ADDRESS <u>BAR HARBOR RD PASADENA MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARDIAC DECOMPENSATION</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u> <u>3 YRS</u> <u>UNKNOWN</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>DEC 4th</u> , 1957, to <u>DEC 4th</u> , 1957, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1:00</u> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Arthur Lankford Jr</u> | | M.D. <u>MOUNTAIN RD PASADENA, MD.</u> | |
| PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/7/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Sicker & Sons - Balto</u> | | 24. REC'D BY REGISTRAR DATE <u>12/5/57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>L. J. Sealy</u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

DEC 10 1953

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12660

CERTIFICATE OF DEATH

Reg. Dist. No.

21

12644

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Harold St.</u> | | | | d. STREET ADDRESS <u>10 Harold St.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Lane</u> Last <u>Lane</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-26-1885</u> yrs. | |
| 9. AGE (In years last birthday) <u>72</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>State Bd. Ag. & C. Md.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Wesley Lane</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Harris</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>214-05-2013A</u> | | | |
| 17. INFORMANT <u>Mary Lane - Annapolis, Md.</u> | | | | Address <u>Annapolis, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO <u>162X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>12/6</u> , 19 <u>57</u> , to <u>12/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/25</u> , 19 <u>57</u> , and that death occurred at <u>10 A.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Theodore H. Graham M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>37 E. Street Annapolis, Md.</u> | | | |
| DATE SIGNED <u>12/20/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-28-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u> | | 22d. LOCATION (City, town, or county) (State) <u>Best State, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, Jr. - Annapolis, Md.</u> | | | | ADDRESS <u>Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>12/20/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lynch</u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | | | | | | | | | |
|------------------------|--|------------------------|--|-----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1922 | | MOBILE, ALABAMA | |
| RESIDENCE | | OCCUPATION | | EDUCATION | | MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | |
| MEMPHIS, TENNESSEE | | ATTORNEY | | HIGH SCHOOL | | MARRIED | | 4/4/68 | | MEMPHIS, TENNESSEE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | |
| HEART DISEASE | | NATURAL | | 1 | | 4/4/68 | | MEMPHIS, TENNESSEE | | 4/4/68 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | |

RECEIVED
 DEC 31 1957
 BUREAU V. 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12645 CERTIFICATE OF DEATH

Reg. Dist. No.

12662

| | | | |
|---|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>HUNNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MO.</u> b. COUNTY <u>A.A.Co. MO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 ARNOHD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>62 ANNE ARUNDEL GENERAL HOSPITAL</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>E.</u> Last <u>LARK</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-17-1897</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>B+A. R.R. Co. Ret.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>JAMES LARK</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY BYERS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>J. LAWRENCE MYERS</u> Address <u>#2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bilateral ureteral obstruction</u> DUE TO <u>3 wks</u> (c) <u>Carcinoma of Prostate Gland</u> DUE TO <u>1 1/2 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>7/4/56</u> , 19 <u>—</u> , to <u>12/29/57</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>12/29/57</u> , 19 <u>—</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Edwin Davis Jr.</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u>Edwin Davis Jr., M.D.</u> 98 Cathedral Street, Annapolis, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1-2-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u> | | 22d. LOCATION (City, town, or county) (State) <u>BROOKLYN MO.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor + Sons</u> ADDRESS <u>Annapolis Md.</u> | | 24. REG'D BY REGISTRAR <u>JAN 3</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>John J. Henry</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12683

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u> | | c. LENGTH OF STAY IN 1b <u>62 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Milton</u> Last <u>Lee</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 7, 1895</u> |
| 9. AGE (In years last birthday) <u>62 yrs.</u> | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Mayo, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | |
| 13. FATHER'S NAME <u>William H. Lee</u> | | 14. MOTHER'S MAIDEN NAME <u>Ellen Rebecca Bullen</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>214-05-1970</u> | |
| 17. INFORMANT <u>George M. Lee, Jr.</u> | | Address <u>Mayo, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>1 year</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>16 minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 6, 1957</u> , to <u>Dec. 20, 1957</u> , that I last saw the deceased alive on <u>Dec 20, 1957</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Sylvia M. Lim</u> | | ADDRESS (Street, city or town, state) DATE SIGNED <u>12/21/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim</u> | | <u>Edgewater, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec 23, 57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Mayo, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> | | 24a. REC'D BY REGISTRAR <u>DEC 23 57</u> | |
| ADDRESS <u>Annapolis, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. M. M. M.</u> | |

DEC 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12684 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12664

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--|------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>125 Bliss Lane</u> | | d. STREET ADDRESS <u>Same</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Thomas Lerch</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>3rd.</u> Year <u>1957</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/7/55</u> |
| 9. AGE (In years last birthday) <u>1 y. 11 m.</u> | | IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Francis John Lerch</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Zimmerman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Mr. F.J. Lerch (father)</u> | |
| 17. INFORMANT <u>Mr. F.J. Lerch (father)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burn of 95% of body</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>916.0</u> DUE TO (c) <u>916.0</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>916.0</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>House caught on fire and baby was alone in the attic.</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year <u>12/30 P.M. 12/3/19 57</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Glen Burnie, A.A. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>12/3/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/6/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u> | | 24a. REC'D BY REGISTRAR <u>DEC 6 1957</u> | |
| ADDRESS <u>Glen Burnie, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>L. J. Kelly</u> | |

FOR STATE
HEALTH DEPT.

1961 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HAWAII STATE DEPARTMENT OF HEALTH - HONOLULU 78

NAME OF DECEASED

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

IMMEDIATE CAUSE

UNDERLYING CAUSE

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VEHICLE REGISTRATION

REGISTERED

EXPIRATION

DATE

TIME

PLACE

BUREAU V. S.

DEC 6 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G223 12-27-57 et

12685

CERTIFICATE OF DEATH

12665

Reg. Dist. No. 28

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore City ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | | | d. STREET ADDRESS 2801 Rayner Ave. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Estelle Middle Lowery Last Lowery | | | | 4. DATE OF DEATH Month 12 Day 5 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Approx. 85 yrs. | |
| 9. AGE (In years last birthday) 85 | | IF UNDER 1 YEAR Months 8 Days 5 Hours 19 Min. 57 | | IF UNDER 24 HRS. Months 8 Days 5 Hours 19 Min. 57 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 715X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Debility DUE TO (c) Multiple Decubitus Ulcers | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis and Senility | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----- | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- | |
| 20f. (City or town) (County) (State) ----- | | | | | | | |
| 21. I certify that I attended the deceased from October 6, 19 54 to December 5, 19 57 , that I last saw the deceased alive on December 5, 19 57 , and that death occurred at 4:00 p. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Lionel McHenry Mapp | | | | ADDRESS (Street, city or town, state) Crownsville, Md. | | DATE SIGNED 12/6/57 | |
| PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. | | | | Crownsville State Hospital | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12-10-57 | | 22c. NAME OF CEMETERY OR CREMATORY Truman Ashbur | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Lan | | | | ADDRESS 302 Madison | | 24a. REC'D BY REGISTRAR DEC 19 1957 | |
| 24b. REGISTRAR'S SIGNATURE W. M. Joyce | | | | | | | |

CERTIFICATE OF DEATH

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| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | | 4. DATE OF BIRTH [Faint text] | | 5. PLACE OF BIRTH [Faint text] | | 6. OCCUPATION [Faint text] | |
| 7. MARITAL STATUS [Faint text] | | 8. COLOR OF SKIN [Faint text] | | 9. HIGHEST GRADE OF SCHOOL [Faint text] | | 10. RELIGION [Faint text] | | 11. SOCIAL SECURITY NUMBER [Faint text] | | 12. MOTHER'S MAIDEN NAME [Faint text] | |
| 13. DATE OF DEATH [Faint text] | | 14. TIME OF DEATH [Faint text] | | 15. PLACE OF DEATH [Faint text] | | 16. CAUSE OF DEATH [Faint text] | | 17. MANNER OF DEATH [Faint text] | | 18. SIGNATURE OF DECEASED [Faint text] | |
| 19. SIGNATURE OF WITNESS [Faint text] | | 20. SIGNATURE OF PHYSICIAN [Faint text] | | 21. SIGNATURE OF CORONER [Faint text] | | 22. SIGNATURE OF JUDGE [Faint text] | | 23. SIGNATURE OF CLERK [Faint text] | | 24. SIGNATURE OF REGISTRAR [Faint text] | |

BUREAU V. 1

DEC 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12646

CERTIFICATE OF DEATH

12666

Reg. Dist. No. "L 21

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | | | c. LENGTH OF STAY IN 1b 10 ANNAPOLIS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md. | | | | d. STREET ADDRESS 1302 McKinley St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MAE Middle VIRGIE Last LYNESS | | | 4. DATE OF DEATH Month DEC Day 5 Year 1957 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Cau | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-1-1885 | |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Teacher | | | | 10b. KIND OF BUSINESS OR INDUSTRY College Teacher | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Jacob HILDEBRAND | | | | 14. MOTHER'S MAIDEN NAME Mae McDERMOTT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 515-24-4689 | | 17. INFORMANT Address U.S. Naval Hospital, Annapolis, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LUNG with Metastasis 163x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Approx. 2 Yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7 Sep , 19 57 , to 5 Dec , 19 57 , that I last saw the deceased alive on 5 Dec , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S.N. Hosp. Anna. Md. DATE SIGNED 6 Dec 1957 ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) CDR F. W. MEYER JR. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 12-6-57 | | 22c. NAME OF CEMETERY OR CREMATORY Troy, Kansas | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home | | | | ADDRESS Annapolis, Md. | | 24a. REC'D BY REGISTRAR DEC 9 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE [Signature] | | | |

DEC 9 1957

RECEIVED

FOR STATE
HEALTH DEPT.

12686

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|-----------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Same STATE Same COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | | c. LENGTH OF STAY IN 1b 3 weeks | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 110 Carroll Road | | e. STREET ADDRESS Same | |
| 3. NAME OF DECEASED (Type or print) Edith A. Marsh | | 4. DATE OF DEATH December 31st 1957 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/23/82 |
| 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired house wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Lucky, Ohio. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Fred Strail | | 14. MOTHER'S MAIDEN NAME Arndt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Rev. Baron M. Marsh (son) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH Sudden | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Gustave H. Faubert, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) Gustave H. Faubert, M.D. | | DATE SIGNED 12/31/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 4, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Troy Township Cem. | | 22d. LOCATION (City, town, or county) (State) Wood Co. Ohio | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. J. Singletary | | 24a. REC'D BY REGISTRAR JAN 13 1958 | |
| ADDRESS Glen Burnie, Md. | | 24b. REGISTRAR'S SIGNATURE L. J. Adley | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 13 1938

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

12345

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten and stamped information.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12667

12687 CERTIFICATE OF DEATH

Reg. Dist. No. 24

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|---|---------------------------|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH COUNTY <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME</u> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>✓</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> OR TOWN <u>3Y01-4</u> STREET ADDRESS (If rural give location) <u>1037 SHARP ST</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>MAXWELL</u> (First) <u>MARY</u> (Last) | | 4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>4</u> (Year) <u>1957</u> | | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>7-4-1878</u> | 9. AGE last birthday <u>79</u> yrs. | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARRION Co. GA.</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>BENJAMIN HANDS</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY HANDS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT & ADDRESS <u>PLAZA MANOR Conv. Home - Glen Burnie</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART DISEASE</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROSIS GENERAL</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 1955</u> , to <u>Dec 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 30 1957</u> and that death occurred at <u>508A</u> M., from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>102 BHA BLVD. N.E. GLEN BURNIE, Md.</u> DATE SIGNED <u>12-4-57</u> M.D. | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>12-7-57</u> | | NAME OF CEMETERY OR CREMATORY <u>Mt. AUBURN Cemetery Baltimore, Md.</u> | | | |
| 24. REC'D BY REGISTRAR <u>DEC 9 1957</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R Law</u> ADDRESS <u>-802 Md.</u> | | | |

1963 CERTIFICATE OF DEATH

Form 100-10-10

1. USUAL RESIDENCE (Street or Post Office)

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. RACE

10. OCCUPATION

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. SOCIAL CLASS

15. PREVIOUS ILLNESS

16. PREVIOUS SURGERY

17. PREVIOUS TRAUMA

18. PREVIOUS DRUGS

19. PREVIOUS ALCOHOL

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246. PREVIOUS OTHER

247. PREVIOUS OTHER

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250. PREVIOUS OTHER

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267. PREVIOUS OTHER

268. PREVIOUS OTHER

269. PREVIOUS OTHER

270. PREVIOUS OTHER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12647

CERTIFICATE OF DEATH

12668

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------|--|---------------------------------------|---|-----------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. LENGTH OF STAY IN 1b <u>2 minute</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Jennie</u> First <u>McCarthy</u> Middle <u>McCarthy</u> Last | | | | 4. DATE OF DEATH <u>Dec.</u> Month <u>15</u> Day <u>1957</u> Year | | | |
| 5. SEX <u>f.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 13, 1872</u> | 9. AGE (In years last birthday) <u>85</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired for 20 years</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u> |
| 13. FATHER'S NAME <u>Charles McCarthy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>If yes, give war or dates of service</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Ka Reine B. Staal</u> Address <u>Woodland Beach Edgewater, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Respiratory failure and Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Orthostatic cardiovascular disease</u> DUE TO (c) <u>1 week</u> 3 years | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Dec. 13</u> , 19 <u>57</u> , to <u>Dec. 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 15</u> , 19 <u>57</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>RFD #1 Box 277-M Edgewater, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim</u> | | | | DATE SIGNED <u>12/15/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12-18-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy., Glen Burnie Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>DEC 18 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lenchy</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

| | | | |
|--------------------|--|-----------------------|--|
| PLACE OF DEATH | | MARRIAGE | |
| 1. PLACE OF DEATH | | 2. DATE OF MARRIAGE | |
| 3. PLACE OF DEATH | | 4. DATE OF MARRIAGE | |
| 5. PLACE OF DEATH | | 6. DATE OF MARRIAGE | |
| 7. PLACE OF DEATH | | 8. DATE OF MARRIAGE | |
| 9. PLACE OF DEATH | | 10. DATE OF MARRIAGE | |
| 11. PLACE OF DEATH | | 12. DATE OF MARRIAGE | |
| 13. PLACE OF DEATH | | 14. DATE OF MARRIAGE | |
| 15. PLACE OF DEATH | | 16. DATE OF MARRIAGE | |
| 17. PLACE OF DEATH | | 18. DATE OF MARRIAGE | |
| 19. PLACE OF DEATH | | 20. DATE OF MARRIAGE | |
| 21. PLACE OF DEATH | | 22. DATE OF MARRIAGE | |
| 23. PLACE OF DEATH | | 24. DATE OF MARRIAGE | |
| 25. PLACE OF DEATH | | 26. DATE OF MARRIAGE | |
| 27. PLACE OF DEATH | | 28. DATE OF MARRIAGE | |
| 29. PLACE OF DEATH | | 30. DATE OF MARRIAGE | |
| 31. PLACE OF DEATH | | 32. DATE OF MARRIAGE | |
| 33. PLACE OF DEATH | | 34. DATE OF MARRIAGE | |
| 35. PLACE OF DEATH | | 36. DATE OF MARRIAGE | |
| 37. PLACE OF DEATH | | 38. DATE OF MARRIAGE | |
| 39. PLACE OF DEATH | | 40. DATE OF MARRIAGE | |
| 41. PLACE OF DEATH | | 42. DATE OF MARRIAGE | |
| 43. PLACE OF DEATH | | 44. DATE OF MARRIAGE | |
| 45. PLACE OF DEATH | | 46. DATE OF MARRIAGE | |
| 47. PLACE OF DEATH | | 48. DATE OF MARRIAGE | |
| 49. PLACE OF DEATH | | 50. DATE OF MARRIAGE | |
| 51. PLACE OF DEATH | | 52. DATE OF MARRIAGE | |
| 53. PLACE OF DEATH | | 54. DATE OF MARRIAGE | |
| 55. PLACE OF DEATH | | 56. DATE OF MARRIAGE | |
| 57. PLACE OF DEATH | | 58. DATE OF MARRIAGE | |
| 59. PLACE OF DEATH | | 60. DATE OF MARRIAGE | |
| 61. PLACE OF DEATH | | 62. DATE OF MARRIAGE | |
| 63. PLACE OF DEATH | | 64. DATE OF MARRIAGE | |
| 65. PLACE OF DEATH | | 66. DATE OF MARRIAGE | |
| 67. PLACE OF DEATH | | 68. DATE OF MARRIAGE | |
| 69. PLACE OF DEATH | | 70. DATE OF MARRIAGE | |
| 71. PLACE OF DEATH | | 72. DATE OF MARRIAGE | |
| 73. PLACE OF DEATH | | 74. DATE OF MARRIAGE | |
| 75. PLACE OF DEATH | | 76. DATE OF MARRIAGE | |
| 77. PLACE OF DEATH | | 78. DATE OF MARRIAGE | |
| 79. PLACE OF DEATH | | 80. DATE OF MARRIAGE | |
| 81. PLACE OF DEATH | | 82. DATE OF MARRIAGE | |
| 83. PLACE OF DEATH | | 84. DATE OF MARRIAGE | |
| 85. PLACE OF DEATH | | 86. DATE OF MARRIAGE | |
| 87. PLACE OF DEATH | | 88. DATE OF MARRIAGE | |
| 89. PLACE OF DEATH | | 90. DATE OF MARRIAGE | |
| 91. PLACE OF DEATH | | 92. DATE OF MARRIAGE | |
| 93. PLACE OF DEATH | | 94. DATE OF MARRIAGE | |
| 95. PLACE OF DEATH | | 96. DATE OF MARRIAGE | |
| 97. PLACE OF DEATH | | 98. DATE OF MARRIAGE | |
| 99. PLACE OF DEATH | | 100. DATE OF MARRIAGE | |

RECEIVED
DEC 18 1957
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12688 CERTIFICATE OF DEATH

12669

Reg. Dist. No.

| | | | |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Anne Arundell</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>a. a.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac Park</i> | | c. LENGTH OF STAY IN 1b <i>15 yrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>214 Zepplin Ave</i> | | d. STREET ADDRESS <i>214 Zepplin Ave</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Francis</i> Middle <i>McClure</i> Last <i>McClure</i> | | 4. DATE OF DEATH Month <i>Dec</i> Day <i>19</i> Year <i>1957</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6 March 1886</i> |
| 9. AGE (In years last birthday) <i>71</i> yrs. | | IF UNDER 1 YEAR: Months <i>71</i> Days <i>71</i> Hours <i>71</i> Min. <i>71</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>South Carolina</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i> | |
| 13. FATHER'S NAME <i>Joseph Layton</i> | | 14. MOTHER'S MAIDEN NAME <i>Catherine Young</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>Joseph McClure</i> | | Address <i>207 Zepplin Ave</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerotic Heart Disease</i> DUE TO (c) <i>Unk.</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <i>o. m.</i> <i>19</i> Month <i>19</i> Day <i>19</i> Year <i>1957</i> p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>1 July</i> , 1952, to <i>18 Dec</i> , 1957, that I last saw the deceased alive on <i>18 Dec</i> , 1957, and that death occurred at <i>9:15 P. M.</i> , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>501 Cherry Hill Road</i> DATE SIGNED <i>Renold B. Lighthston, Jr.</i> | |
| ACTUAL SIGNATURE <i>Renold B. Lighthston, Jr.</i> M.D. | | PHYSICIAN'S NAME (Type) <i>Renold B. Lighthston, Jr. M.D. Baltimore - 25 Md.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 22b. DATE THEREOF <i>12/23/57</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>MT. CAL. CEM.</i> | | 22d. LOCATION (City, town, or county) (State) <i>BROOKLAND AA. CO MD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>ELROY D. WILSON</i> | | ADDRESS <i>1800 BRANTLEY AVE</i> | |
| 24. REC'D BY REGISTRAR <i>DEC 26 '57</i> | | 24b. REGISTRAR'S SIGNATURE <i>DeLoach</i> | |

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DEC 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12689 CERTIFICATE OF DEATH

Reg. Dist. No.

126708

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>A.A. Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, Md - 3401-4</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE STATE HOSPITAL</u> | | d. STREET ADDRESS <u>1310, Argyle Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>MERCER</u> Last <u>MERCER</u> | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/10/1885</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | 11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Charles Bennett</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Elvora Bennett</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | |
| 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address <u>Mrs Effie Wornley 2453 Druid Hill</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SENILE CACHEXIA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS - 7 yrs.</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MYOCARDIAL DEGENERATION</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>6/3/1948</u> , to <u>12/14/1957</u> , that I last saw the deceased alive on <u>12/14/1957</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Ludwig Benedikt</u> | | ADDRESS (Street, city or town, state) DATE SIGNED <u>CROWNSVILLE STATE HOSPITAL</u> <u>12/14/57</u> | |
| PHYSICIAN'S NAME (Type) <u>LUDWIG BENEDIKT</u> | | M.D. <u>CROWNSVILLE, Md - 12/14/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Dec. 18, 57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto. C. T. Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Jackson</u> | | 24a. REC'D BY REGISTRAR DATE <u>17 1957</u> | |
| ADDRESS <u>916 Penn. Ave.</u> | | 24b. REGISTRAR'S SIGNATURE <u>A.M. Jagan</u> | |

STATE OF MASSACHUSETTS DEPARTMENT OF HEALTH BUREAU OF VITAL RECORDS CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|------------------|--|------------------|--|-------------------|--|----------------|--|------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES J. JONES | | 45 | | M | | W | | JAN 15 1912 | | NEW YORK CITY | |
| MARRIED | | WIFE'S NAME | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | OCCUPATION | | EDUCATION | |
| YES | | MARY J. JONES | | JUN 15 1935 | | NEW YORK CITY | | CLERK | | HIGH SCHOOL | |
| CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | TIME OF DEATH | | SIGNATURE OF PHYSICIAN | |
| HEART DISEASE | | NATURAL | | HOSPITAL | | DEC 10 1957 | | 10:30 AM | | J. J. JONES | |
| DETAILS OF DEATH | | PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | |
| HEART DISEASE | | NO | | NO | | NO | | NO | | NO | |
| DETAILS OF DEATH | | PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | |
| HEART DISEASE | | NO | | NO | | NO | | NO | | NO | |
| DETAILS OF DEATH | | PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | |
| HEART DISEASE | | NO | | NO | | NO | | NO | | NO | |

James J. Jones

RECEIVED
DEC 17 1957
BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
100 STATE STREET, 10TH FLOOR
BOSTON, MASSACHUSETTS 02109
TELEPHONE 523-1234
FAX 523-1234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12648

CERTIFICATE OF DEATH

12671

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY A. A. Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY A. A. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | | | c. LENGTH OF STAY IN 1b 10 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 35 PINKNEY | | | | e. STREET ADDRESS 35 PINKNEY | | | |
| 3. NAME OF DECEASED (Type or print) JANIE-ELLEN-ARMSTRONG-MILLER | | | | 4. DATE DECEASED Dec 27 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Col | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH UNKNOWN | |
| 9. AGE (In years last birthday) 70 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grass-Picker-Seafood Co. | | 10b. KIND OF BUSINESS OR INDUSTRY ANNE ARUNDEL Co. | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME Robert S. Armstrong | | | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | |
| 16. SOCIAL SECURITY NO. 214-05-0308 | | | | 17. INFORMANT WILLIAM D. ARMSTRONG-IRVING | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Coronary Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 434.1 DUE TO (c) 434.1 | | | | 19. INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 12-27-57 , 19 57 , to 12-27-57 , 19 57 , that I last saw the deceased alive on 12-27-57 , 19 57 , and that death occurred at 8:15 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A. T. Allen | | | | DATE SIGNED Dec 27 1957 | | | |
| PHYSICIAN'S NAME (Type) A. T. ALLEN | | | | ADDRESS (Street, city or town, state) ANNAPOLIS Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12-30-57 | | 22c. NAME OF CEMETERY OR CREMATORY Brewer-Hill | | 22d. LOCATION (City, town, or county) (State) ANNAPOLIS Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks | | | | 24a. REC'D BY REGISTRAR U. D. Smith | | | |
| ADDRESS ANNAPOLIS-Md | | | | DATE 30 1957 | | | |

G. E. HICKS III
ANNABOLIZ - W. 9.

RECEIVED

DEC 31 1957

BUREAU V. S.

No 214-02-0308 William D. Armstrong - Living
Washington - D.C. 204
Robert S. Armstrong
Charles - Parker - Sanford Co.
Anne Arundel Co.
Unknown
Book E

Female Col X Unknown
JANIE-ELLEN-ARMSTRONG-MILLER
Dec 27 21

32 Pinkney
Annabopolis
A.A. Co.
32 Pinkney
Annabopolis
M.D.
A.A.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The same copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12690 CERTIFICATE OF DEATH

12672

Reg. Dist. No. 24

| | | | | | | | |
|---|------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park (Glen Burnie P.O.)</u> | | LENGTH OF STAY (in this place) <u>12 years</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park (Glen Burnie P.O.)</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Wendover Road</u> | | | | STREET ADDRESS (If rural give location) <u>14 Wendover Road</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>FRANK</u> (Middle) <u>LEE</u> (Last) <u>MOORE</u> | | | | (Month) <u>DECEMBER</u> (Day) <u>4</u> (Year) <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>July 6, 1890</u> | 9. AGE last birthday <u>67</u> yrs. | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Lee Moore</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Harian Dunkin</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>W.W. I</u> | | 17. INFORMANT & ADDRESS <u>Mrs. Ruth A. Moore</u> | | <u>Same as #2</u> | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>ACUTE MYOCARDIAL INFARCT</u> | | | | <u>minute</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____ el work <input type="checkbox"/> Not while el work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Aug 21</u> , 19 <u>49</u> , to <u>12/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/16</u> , 19 <u>56</u> , and that death occurred at <u>11 A.</u> M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Bayard L. Jones</u> | | | | ADDRESS (Street, city, town, state) <u>104 Grain Hwy S Glen Burnie</u> | | DATE SIGNED <u>12/6/57</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Dec 7/57</u> | | NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | | LOCATION (City, town, or county) (State) <u>Glen Burnie</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>R. J. Bell</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Bell</u> | | ADDRESS <u>Glen Burnie, Md</u> | |
| DATE <u>DEC 9 1957</u> | | | | | | | |

12830 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO.

1. NAME, RESIDENCE, SEX, AGE, OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

USUAL PLACE OF RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERIODIC EXAMINATION

DATE OF EXAMINATION

PLACE OF EXAMINATION

EXAMINER'S SIGNATURE

DATE OF SIGNATURE

PLACE OF SIGNATURE

EXAMINER'S TITLE

DATE OF TITLE

PLACE OF TITLE

EXAMINER'S ADDRESS

DATE OF ADDRESS

PLACE OF ADDRESS

EXAMINER'S PHONE

DATE OF PHONE

PLACE OF PHONE

EXAMINER'S FAX

DATE OF FAX

PLACE OF FAX

EXAMINER'S E-MAIL

DATE OF E-MAIL

PLACE OF E-MAIL

EXAMINER'S SIGNATURE

DATE OF SIGNATURE

PLACE OF SIGNATURE

EXAMINER'S TITLE

DATE OF TITLE

PLACE OF TITLE

EXAMINER'S ADDRESS

DATE OF ADDRESS

PLACE OF ADDRESS

EXAMINER'S PHONE

DATE OF PHONE

PLACE OF PHONE

None

Lee

Frank

W

M

December 4

Acute Myocardial Infarct
Arteriosclerotic Cardio-Vascular Disease

BUREAU V. 3

DEC 9 1957

RECEIVED

Requiescat in Pace

INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12691 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12673

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | c. LENGTH OF STAY IN 1b Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Herald Harbor Road | | | | e. STREET ADDRESS Old Herald Harbor Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) REBECCA MULLENAX | | | | 4. DATE OF DEATH Month December Day 17 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 47 yrs. | |
| 9. AGE (In years last birthday) 47 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress (Part time) | | 11. BIRTHPLACE (State or foreign country) Crownsville, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Cox | | | | 14. MOTHER'S MAIDEN NAME Leona Stein | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 11111 | | 17. INFORMANT Mr. Roland Mullenax, Jr. Address Edgewater, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage into the chest due to gunshot wound of chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 981X DUE TO (c) gunshot wound of chest | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shot by son-in-law | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 3:30 12/17 19 57 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) (County) (State) Crownsville A.A. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE William V. Lovitt, Jr. | | EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 12/17/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec-20, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Glen Burnie, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. S. Singleton | | ADDRESS Glen Burnie, Md. | | 24a. REC'D BY REGISTRAR DEC 20 1957 | | 24b. REGISTRAR'S SIGNATURE J. M. Joyce | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 10 1957

BUREAU V. 2

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BACINORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12649 CERTIFICATE OF DEATH

12674 2/1

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | | c. LENGTH OF STAY IN 1b 1 hour | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mabel Middle NAYLOR Last NAYLOR | | | | 4. DATE OF DEATH Month Dec. Day 26 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-1-1901 | | 9. AGE (In years last birthday) 56 yrs. | IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min. | IF UNDER 24 HRS. Hours 6 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Ben Brown | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 318-26-8136 | | 17. INFORMANT Frank Naylor - Mayo, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute oedema of the lung 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 527.2 DUE TO (c) 527.2 | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hours | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 26 , 19 57 , to Dec 26 , 19 57 , that I last saw the deceased alive on Dec 26 , 19 57 , and that death occurred at 8:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Davidsonville, Md. DATE SIGNED Dec 31 1957 | | | | | | | |
| ACTUAL SIGNATURE Albert H. Anderson M.D. | | | | DATE SIGNED Dec 31 1957 | | | |
| PHYSICIAN'S NAME (Type) | | | | 22a. REC'D BY REGISTRAR | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 12-31-57 | | 22c. NAME OF CEMETERY OR CREMATORY Union Chapel | |
| 22d. LOCATION (City, town, or county) (State) Davidsonville, Md. | | | | 22e. REGISTRAR'S SIGNATURE Wm. J. French | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md. | | | | 24. ADDRESS 12674 2/1 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

| | | | | | | | |
|----------------------------------|--|-------------------------------|--|----------------------------|--|---------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | |
| 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. MARITAL STATUS | | 8. CAUSE OF DEATH | |
| 9. PLACE OF DEATH | | 10. DATE OF DEATH | | 11. TIME OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF DECEASED | | 16. SIGNATURE OF NEXT OF KIN | |
| 17. SIGNATURE OF BURIAL OFFICIAL | | 18. SIGNATURE OF FUNERAL HOME | | 19. SIGNATURE OF CEMETERY | | 20. SIGNATURE OF CHURCH | |
| 21. SIGNATURE OF MINISTERS | | 22. SIGNATURE OF MUSICIANS | | 23. SIGNATURE OF FLORISTS | | 24. SIGNATURE OF COFFIN MAKERS | |
| 25. SIGNATURE OF CATERERS | | 26. SIGNATURE OF BAKERS | | 27. SIGNATURE OF BUTCHERS | | 28. SIGNATURE OF FLOWER VENDORS | |
| 29. SIGNATURE OF MUSICIANS | | 30. SIGNATURE OF MUSICIANS | | 31. SIGNATURE OF MUSICIANS | | 32. SIGNATURE OF MUSICIANS | |
| 33. SIGNATURE OF MUSICIANS | | 34. SIGNATURE OF MUSICIANS | | 35. SIGNATURE OF MUSICIANS | | 36. SIGNATURE OF MUSICIANS | |
| 37. SIGNATURE OF MUSICIANS | | 38. SIGNATURE OF MUSICIANS | | 39. SIGNATURE OF MUSICIANS | | 40. SIGNATURE OF MUSICIANS | |
| 41. SIGNATURE OF MUSICIANS | | 42. SIGNATURE OF MUSICIANS | | 43. SIGNATURE OF MUSICIANS | | 44. SIGNATURE OF MUSICIANS | |
| 45. SIGNATURE OF MUSICIANS | | 46. SIGNATURE OF MUSICIANS | | 47. SIGNATURE OF MUSICIANS | | 48. SIGNATURE OF MUSICIANS | |
| 49. SIGNATURE OF MUSICIANS | | 50. SIGNATURE OF MUSICIANS | | 51. SIGNATURE OF MUSICIANS | | 52. SIGNATURE OF MUSICIANS | |
| 53. SIGNATURE OF MUSICIANS | | 54. SIGNATURE OF MUSICIANS | | 55. SIGNATURE OF MUSICIANS | | 56. SIGNATURE OF MUSICIANS | |
| 57. SIGNATURE OF MUSICIANS | | 58. SIGNATURE OF MUSICIANS | | 59. SIGNATURE OF MUSICIANS | | 60. SIGNATURE OF MUSICIANS | |
| 61. SIGNATURE OF MUSICIANS | | 62. SIGNATURE OF MUSICIANS | | 63. SIGNATURE OF MUSICIANS | | 64. SIGNATURE OF MUSICIANS | |
| 65. SIGNATURE OF MUSICIANS | | 66. SIGNATURE OF MUSICIANS | | 67. SIGNATURE OF MUSICIANS | | 68. SIGNATURE OF MUSICIANS | |
| 69. SIGNATURE OF MUSICIANS | | 70. SIGNATURE OF MUSICIANS | | 71. SIGNATURE OF MUSICIANS | | 72. SIGNATURE OF MUSICIANS | |
| 73. SIGNATURE OF MUSICIANS | | 74. SIGNATURE OF MUSICIANS | | 75. SIGNATURE OF MUSICIANS | | 76. SIGNATURE OF MUSICIANS | |
| 77. SIGNATURE OF MUSICIANS | | 78. SIGNATURE OF MUSICIANS | | 79. SIGNATURE OF MUSICIANS | | 80. SIGNATURE OF MUSICIANS | |
| 81. SIGNATURE OF MUSICIANS | | 82. SIGNATURE OF MUSICIANS | | 83. SIGNATURE OF MUSICIANS | | 84. SIGNATURE OF MUSICIANS | |
| 85. SIGNATURE OF MUSICIANS | | 86. SIGNATURE OF MUSICIANS | | 87. SIGNATURE OF MUSICIANS | | 88. SIGNATURE OF MUSICIANS | |
| 89. SIGNATURE OF MUSICIANS | | 90. SIGNATURE OF MUSICIANS | | 91. SIGNATURE OF MUSICIANS | | 92. SIGNATURE OF MUSICIANS | |
| 93. SIGNATURE OF MUSICIANS | | 94. SIGNATURE OF MUSICIANS | | 95. SIGNATURE OF MUSICIANS | | 96. SIGNATURE OF MUSICIANS | |
| 97. SIGNATURE OF MUSICIANS | | 98. SIGNATURE OF MUSICIANS | | 99. SIGNATURE OF MUSICIANS | | 100. SIGNATURE OF MUSICIANS | |

RECEIVED
DEC 31 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12650

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. 12675 21

FOR STATE
HEALTH DEPT.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>a.a.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riva</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Riva</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>JENNIE SUE NELSON</u> | | 4. DATE OF DEATH <u>December 31 1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 11, 1957</u> |
| 9. AGE (in years last birthday) <u>21</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>21</u> Days <u>0</u> Hours <u>0</u> Min. | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>HARRY G. NELSON</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY RYAN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>HARRY G. NELSON</u> | | Address <u>#2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Otitis media, bilateral</u> <u>391.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause lost. DUE TO (c) <u>—</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Russell S. Fisher</u> | | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1-3-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Arhington Nat'l.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arhington VA.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> | | ADDRESS <u>Annapolis, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 3 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>Am. Trench</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12692

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12676

Reg. Dist. No. 27

| | | | |
|--|--------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Kings</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u> | | c. LENGTH OF STAY IN 1b <u>1 moth 5 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Army Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>O'HARE</u> Last <u>O'HARE</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>19 57</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Can</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>14 Feb 1885</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Cornelius O'Leary</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Honorka Donohue</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Son/Timothy F. O'Hare, Bldg T-2325, Ft Meade, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. EXTERNAL CAUSE WAS <u> </u> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>10 December 57</u> | |
| 22a. DATE OF REMOVAL (Specify) <u>12/11/57</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Brooklyn, New York</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Woberton Funeral Home, Inc.</u> | | 24. REC'D BY REGISTRAR <u>Wilbur H. Dawns, Jr. Capt. 1130</u> | |
| ADDRESS <u>6306 - Belair Rd, Baltimore-6, Md</u> | | 24. REGISTRAR'S SIGNATURE | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF EXAMINER: [illegible]
10. DATE OF EXAMINATION: [illegible]

BUREAU V. S.

DEC 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12651

CERTIFICATE OF DEATH

12677

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>W.C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>135 St. Washington St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Parker</u> Last <u>Parker</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OF RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 17, 1957</u> |
| 9. AGE (In years lost birthday) yrs. <u>4</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Bernard Parker</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Ferguson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>_____</u> | |
| 17. INFORMANT <u>Bernard Parker - Annapolis, Md.</u> | | Address <u>_____</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>773.0</u> DUE TO <u>Congenital Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>_____</u> DUE TO <u>_____</u> (c) <u>_____</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day.</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>12/29</u> , 19 <u>57</u> , to <u>12/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>57</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Herbert H. Johnson</u> M.D. | | ADDRESS (Street, city or town, state) <u>37 Baker St. Annapolis, Md.</u> | |
| DATE SIGNED <u>DEC 31 1957</u> | | PHYSICIAN'S NAME (Type) <u>William Reese, Jr. Annapolis, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>12-30-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR <u>_____</u> 24b. REGISTRAR'S SIGNATURE <u>_____</u> | |

2063292XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12652

CERTIFICATE OF DEATH

12678

Reg. Dist. No. 21

| | | | |
|--|--------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u> | | d. STREET ADDRESS <u>WEEMS CREEK</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>EDGAR</u> Last <u>PEIFER</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cau</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6 May 1896</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY (Retired)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> | |
| 13. FATHER'S NAME <u>ELMER PEIFER</u> | | 14. MOTHER'S MAIDEN NAME <u>ALICE MOSLER</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u> | | 16. SOCIAL SECURITY NO. <u> - - - -</u> | |
| 17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INFARCTION MYOCARDIUM</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>18 December, 1957</u> , to <u>18 December, 1957</u> , that I last saw the deceased alive on <u>18 December, 1957</u> , and that death occurred at <u>4:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hosp. Annapolis, Md.</u> DATE SIGNED <u>12-19-57</u> ACTUAL SIGNATURE <u>F. W. MEYER JR.</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>F. W. MEYER JR. CDR MC USN</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u> | | 22b. DATE THEREOF <u>12-21-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Easton Hgts. Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Easton, Pennsylvania</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> | | 24a. REC'D BY REGISTRAR <u>DEC 23 '57</u> | |
| ADDRESS <u>Annapolis, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

DEC 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 12679 | | |
|--|--|--------------------------------------|--|---|--|--------------------------------------|--|---|--|---|--|--|
| 12653 | | | | | | | | | | 11410 | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. | | |
| Item 4, Film G-225 -2/26/58.cc. | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>a a</i> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> | | | | | c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>a a General</i> | | | | | d. STREET ADDRESS <i>95 Conduit</i> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>H.</i> Last <i>Pollock</i> | | | | | 4. DATE OF DEATH Month <i>Dec.</i> Day <i>24</i> Year <i>1957</i> | | | | | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>3-22-1894</i> | | 9. AGE (In years last birthday) <i>63</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Morristown N. J.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>N. S. A</i> | | | |
| 13. FATHER'S NAME <i>John Andrew Young</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Eizabeth H. Hughes</i> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) | | | | | 16. SOCIAL SECURITY NO. <i>-</i> | | 17. INFORMANT <i>Harrison Pollock</i> | | Address <i>(2)</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyperinsulin</i> <i>443X</i> DUE TO <i>Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <i>Sudden</i> (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>E. L. Linhardt</i> | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED <i>12/24/57</i> | | |
| EXAMINER'S NAME (Type) <i>E. L. Linhardt</i> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12-25-57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Naval Academy</i> | | | 22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i> | | | | | ADDRESS <i>Annapolis Md</i> | | 24a. REC'D BY REGISTRAR DATE <i>12/26/57</i> | | 24b. REGISTRAR'S SIGNATURE <i>U. Brown</i> | | | |

RECEIVED
BUREAU V. S.
DEC 30 1937

RECEIVED
BUREAU V. S.
DEC 30 1937

RECEIVED
BUREAU V. S.
DEC 30 1937

STATE OF NEW YORK
COUNTY OF []
IN SENATE
JANUARY 1, 1938

REPORT OF THE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED []
AGE []
SEX []
RACE []
DATE OF DEATH []
PLACE OF DEATH []
CAUSE OF DEATH []
MANNER OF DEATH []
SIGNATURE OF MEDICAL EXAMINER []
OFFICE OF MEDICAL EXAMINER []

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12693

Item 11 Film G224 1-24-58 et

CERTIFICATE OF DEATH

12680

Reg. Dist. No.

| | | | |
|---|--------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY a. arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE | | c. LENGTH OF STAY IN 1b 2 1/2 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LAST POWELL , (X) Middle ANNIE First ANNIE | | 4. DATE OF DEATH Month DEC. Day 3 Year 1957 | |
| 5. SEX F. | 6. COLOR OR RACE Cobred | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-21-1876 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (State or foreign country) Tracy's, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME JOS. COATES | | 14. MOTHER'S MAIDEN NAME NOT KNOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. --- | |
| 17. INFORMANT --- | | Address --- | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia 450.0 DUE TO Arteriosclerosis General Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug , 19 55 , to Dec 3 , 19 57 , that I last saw the deceased alive on Nov 30 , 19 57 , and that death occurred at 10:55 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph Taler M.D. | | ADDRESS (Street, city or town, state) 10204 A Blvd. M.E. | |
| PHYSICIAN'S NAME (Type) JOSEPH TALER | | DATE SIGNED 12-4-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/8/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Union Chapel | | 22d. LOCATION (City, town, or county) (State) McKendree, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty ADDRESS Salisbury, Md. | | 24a. REC'D BY REGISTRAR 12/10/57 | |
| | | 24b. REGISTRAR'S SIGNATURE U. Ormish | |

BUREAU V. S.

DEC 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12694 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|---------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> | | | | c. LENGTH OF STAY IN 1b <u>6 mo.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>310 Hill Top Rd.</u> | | | | d. STREET ADDRESS <u>1310 Hill Top Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Catherine S.</u> Middle <u>Powell</u> Last _____ | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1957</u> | | | |
| 5. SEX <u>7</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/13/66</u> | 9. AGE (In years last birthday) <u>91</u> yrs. | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry Jacob Sauters</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Meot.</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u> | | 17. INFORMANT Address <u>Jessie C. Council - (Same)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO <u>Bleeding from rectum -</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5-6 pm -</u> <u>6 hrs -</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Nov 20, 1957 to Dec 8, 1957</u> , that I last saw the deceased alive on <u>Dec 8, 1957</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D. <u>Linthicum</u> | | | | ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12/8/57</u> | | | |
| PHYSICIAN'S NAME (Type) _____ | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-16-57</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mr. Council</u> | | 22d. LOCATION (City, town, or county) <u>Baltimore Md.</u> (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>305 Bay Harbor</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 12 57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page One of Two

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | | 4. RACE [Faint text] | | 5. DATE OF BIRTH [Faint text] | | 6. PLACE OF BIRTH [Faint text] | | 7. MARITAL STATUS [Faint text] | | 8. OCCUPATION [Faint text] | | 9. CAUSE OF DEATH [Faint text] | | 10. MANNER OF DEATH [Faint text] | | 11. SIGNATURE OF DECEASED [Faint text] | | 12. SIGNATURE OF WITNESS [Faint text] | | 13. SIGNATURE OF PHYSICIAN [Faint text] | | 14. SIGNATURE OF CORONER [Faint text] | | 15. SIGNATURE OF JURY [Faint text] | | 16. SIGNATURE OF JUDGE [Faint text] | | 17. SIGNATURE OF CLERK [Faint text] | | 18. SIGNATURE OF REGISTRAR [Faint text] | | 19. SIGNATURE OF OFFICIAL [Faint text] | | 20. SIGNATURE OF OFFICIAL [Faint text] | | 21. SIGNATURE OF OFFICIAL [Faint text] | | 22. SIGNATURE OF OFFICIAL [Faint text] | | 23. SIGNATURE OF OFFICIAL [Faint text] | | 24. SIGNATURE OF OFFICIAL [Faint text] | | 25. SIGNATURE OF OFFICIAL [Faint text] | | 26. SIGNATURE OF OFFICIAL [Faint text] | | 27. SIGNATURE OF OFFICIAL [Faint text] | | 28. SIGNATURE OF OFFICIAL [Faint text] | | 29. SIGNATURE OF OFFICIAL [Faint text] | | 30. SIGNATURE OF OFFICIAL [Faint text] | | 31. SIGNATURE OF OFFICIAL [Faint text] | | 32. SIGNATURE OF OFFICIAL [Faint text] | | 33. SIGNATURE OF OFFICIAL [Faint text] | | 34. SIGNATURE OF OFFICIAL [Faint text] | | 35. SIGNATURE OF OFFICIAL [Faint text] | | 36. SIGNATURE OF OFFICIAL [Faint text] | | 37. SIGNATURE OF OFFICIAL [Faint text] | | 38. SIGNATURE OF OFFICIAL [Faint text] | | 39. SIGNATURE OF OFFICIAL [Faint text] | | 40. SIGNATURE OF OFFICIAL [Faint text] | | 41. SIGNATURE OF OFFICIAL [Faint text] | | 42. SIGNATURE OF OFFICIAL [Faint text] | | 43. SIGNATURE OF OFFICIAL [Faint text] | | 44. SIGNATURE OF OFFICIAL [Faint text] | | 45. SIGNATURE OF OFFICIAL [Faint text] | | 46. SIGNATURE OF OFFICIAL [Faint text] | | 47. SIGNATURE OF OFFICIAL [Faint text] | | 48. SIGNATURE OF OFFICIAL [Faint text] | | 49. SIGNATURE OF OFFICIAL [Faint text] | | 50. SIGNATURE OF OFFICIAL [Faint text] | | 51. SIGNATURE OF OFFICIAL [Faint text] | | 52. SIGNATURE OF OFFICIAL [Faint text] | | 53. SIGNATURE OF OFFICIAL [Faint text] | | 54. SIGNATURE OF OFFICIAL [Faint text] | | 55. SIGNATURE OF OFFICIAL [Faint text] | | 56. SIGNATURE OF OFFICIAL [Faint text] | | 57. SIGNATURE OF OFFICIAL [Faint text] | | 58. SIGNATURE OF OFFICIAL [Faint text] | | 59. SIGNATURE OF OFFICIAL [Faint text] | | 60. SIGNATURE OF OFFICIAL [Faint text] | | 61. SIGNATURE OF OFFICIAL [Faint text] | | 62. SIGNATURE OF OFFICIAL [Faint text] | | 63. SIGNATURE OF OFFICIAL [Faint text] | | 64. SIGNATURE OF OFFICIAL [Faint text] | | 65. SIGNATURE OF OFFICIAL [Faint text] | | 66. SIGNATURE OF OFFICIAL [Faint text] | | 67. SIGNATURE OF OFFICIAL [Faint text] | | 68. SIGNATURE OF OFFICIAL [Faint text] | | 69. SIGNATURE OF OFFICIAL [Faint text] | | 70. SIGNATURE OF OFFICIAL [Faint text] | | 71. SIGNATURE OF OFFICIAL [Faint text] | | 72. SIGNATURE OF OFFICIAL [Faint text] | | 73. SIGNATURE OF OFFICIAL [Faint text] | | 74. SIGNATURE OF OFFICIAL [Faint text] | | 75. SIGNATURE OF OFFICIAL [Faint text] | | 76. SIGNATURE OF OFFICIAL [Faint text] | | 77. SIGNATURE OF OFFICIAL [Faint text] | | 78. SIGNATURE OF OFFICIAL [Faint text] | | 79. SIGNATURE OF OFFICIAL [Faint text] | | 80. SIGNATURE OF OFFICIAL [Faint text] | | 81. SIGNATURE OF OFFICIAL [Faint text] | | 82. SIGNATURE OF OFFICIAL [Faint text] | | 83. SIGNATURE OF OFFICIAL [Faint text] | | 84. SIGNATURE OF OFFICIAL [Faint text] | | 85. SIGNATURE OF OFFICIAL [Faint text] | | 86. SIGNATURE OF OFFICIAL [Faint text] | | 87. SIGNATURE OF OFFICIAL [Faint text] | | 88. SIGNATURE OF OFFICIAL [Faint text] | | 89. SIGNATURE OF OFFICIAL [Faint text] | | 90. SIGNATURE OF OFFICIAL [Faint text] | | 91. SIGNATURE OF OFFICIAL [Faint text] | | 92. SIGNATURE OF OFFICIAL [Faint text] | | 93. SIGNATURE OF OFFICIAL [Faint text] | | 94. SIGNATURE OF OFFICIAL [Faint text] | | 95. SIGNATURE OF OFFICIAL [Faint text] | | 96. SIGNATURE OF OFFICIAL [Faint text] | | 97. SIGNATURE OF OFFICIAL [Faint text] | | 98. SIGNATURE OF OFFICIAL [Faint text] | | 99. SIGNATURE OF OFFICIAL [Faint text] | | 100. SIGNATURE OF OFFICIAL [Faint text] | |
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BUREAU V. S.

DEC 12 1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12682

Reg. Dist. No.

21

| | | | |
|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md. 10</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. General Hospital</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Susie Mae Queen</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-16-1957</u> |
| 9. AGE (In years last birthday) <u>6</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Louis Queen</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Queen</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Louis Queen</u> | | 18. ADDRESS <u>Baltimore Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (d), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO (b) <u>neumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u> DUE TO (c) <u>None</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-22-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u> | | 22d. LOCATION (City, town, or county) (State) <u>Chesterfield Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Egan</u> | | ADDRESS <u>1000 E. Egan</u> | |
| 24a. REC'D BY REGISTRAR <u>Dr. J. French</u> | | 24b. REGISTRAR'S SIGNATURE <u>Dr. J. French</u> | |

2063352 XV7

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.
DEC 27 1957

BUREAU V. S.

DEC 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12695
CERTIFICATE OF DEATH

12683
24

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Annarundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millsville | c. LENGTH OF STAY IN 1b 2 Years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 1 Foxwell Road | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Albert Middle S. Last Rogers | | 4. DATE OF DEATH Month December Day 21 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 20, 1878 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79 | IF UNDER 24 HRS. Months 79 Days 79 Hours 79 Min. 79 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME William C. Rogers | | 14. MOTHER'S MAIDEN NAME Mary Barbine | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT James A. Rogers Address Foxwell Road, Millsville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cerebro-vascular disease DUE TO (c) 2 years | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 16, 1955 , to Dec. 21, 1957 , that I last saw the deceased alive on Dec. 20, 1957 , and that death occurred at 9:15 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R. M. McLaughlin M.D. Paradise, Maryland | | DATE SIGNED Dec. 21, 1957 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec 21, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St. | | 24a. REC'D BY REGISTRAR DEC 27 1957 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE L. J. Dealy | |

DEC 27 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12696 CERTIFICATE OF DEATH

12684

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>G.A. Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>G.A. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> X0 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u> | | e. STREET ADDRESS <u>324 Forest Glen Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Wladyslaw Walter Schmidt</u> | | 4. DATE OF DEATH Month Day Year <u>Dec 26 1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 2 1889</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longsherman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Adam Schmidt</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Zimmerman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>Katherine Schmidt Wife</u> | |
| 17. INFORMANT Address <u>Katherine Schmidt Wife</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY FAILURE</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERAL "CONSUMPTION," ANEMIA (SEC)</u> DUE TO <u>CARCINOMA OF THE RECTUM + METAST.</u> (c) <u>18 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u> | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-1</u> , 19 <u>57</u> , to <u>12-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-29</u> , 19 <u>57</u> , and that death occurred at <u>1 p. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>OTTO Vogel MD</u> M.D. | | ADDRESS (Street, city or town, state) <u>BOX 91-A, PASADENA</u> | |
| DATE SIGNED <u>12-27-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>OTTO VOGEL</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec 30/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozagowski</u> ADDRESS <u>1930 Eastown</u> | | 24a. REC'D BY REGISTRAR <u>L. J. Schallap</u> DATE <u>1/30/57</u> | |
| 24b. REGISTRAR'S SIGNATURE | | | |

CERTIFICATE OF DEATH

15000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

15000

| | | | |
|--------------------------|--|---------------------------|--|
| PLACE OF DEATH | | DATE OF DEATH | |
| 1. NAME OF DECEASED | | 2. SEX | |
| 3. AGE | | 4. RACE | |
| 5. OCCUPATION | | 6. CAUSE OF DEATH | |
| 7. PLACE OF BIRTH | | 8. DATE OF BIRTH | |
| 9. MARITAL STATUS | | 10. EDUCATION | |
| 11. RELIGION | | 12. SOCIAL CLASS | |
| 13. PREVIOUS ILLNESS | | 14. MEDICAL HISTORY | |
| 15. TREATMENT | | 16. PHYSICIAN'S SIGNATURE | |
| 17. CORONER'S SIGNATURE | | 18. MORTUARY CODE | |
| 19. DATE OF INTERMENT | | 20. PLACE OF INTERMENT | |
| 21. NAME OF FUNERAL HOME | | 22. NAME OF MINISTER | |
| 23. NAME OF CHURCH | | 24. NAME OF CEMETERY | |
| 25. NAME OF BURIAL PLACE | | 26. NAME OF CREMATOR | |
| 27. NAME OF INCINERATOR | | 28. NAME OF URN | |
| 29. NAME OF CASK | | 30. NAME OF COFFIN | |
| 31. NAME OF CASK | | 32. NAME OF COFFIN | |
| 33. NAME OF CASK | | 34. NAME OF COFFIN | |
| 35. NAME OF CASK | | 36. NAME OF COFFIN | |
| 37. NAME OF CASK | | 38. NAME OF COFFIN | |
| 39. NAME OF CASK | | 40. NAME OF COFFIN | |
| 41. NAME OF CASK | | 42. NAME OF COFFIN | |
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| 45. NAME OF CASK | | 46. NAME OF COFFIN | |
| 47. NAME OF CASK | | 48. NAME OF COFFIN | |
| 49. NAME OF CASK | | 50. NAME OF COFFIN | |
| 51. NAME OF CASK | | 52. NAME OF COFFIN | |
| 53. NAME OF CASK | | 54. NAME OF COFFIN | |
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| 57. NAME OF CASK | | 58. NAME OF COFFIN | |
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| 61. NAME OF CASK | | 62. NAME OF COFFIN | |
| 63. NAME OF CASK | | 64. NAME OF COFFIN | |
| 65. NAME OF CASK | | 66. NAME OF COFFIN | |
| 67. NAME OF CASK | | 68. NAME OF COFFIN | |
| 69. NAME OF CASK | | 70. NAME OF COFFIN | |
| 71. NAME OF CASK | | 72. NAME OF COFFIN | |
| 73. NAME OF CASK | | 74. NAME OF COFFIN | |
| 75. NAME OF CASK | | 76. NAME OF COFFIN | |
| 77. NAME OF CASK | | 78. NAME OF COFFIN | |
| 79. NAME OF CASK | | 80. NAME OF COFFIN | |
| 81. NAME OF CASK | | 82. NAME OF COFFIN | |
| 83. NAME OF CASK | | 84. NAME OF COFFIN | |
| 85. NAME OF CASK | | 86. NAME OF COFFIN | |
| 87. NAME OF CASK | | 88. NAME OF COFFIN | |
| 89. NAME OF CASK | | 90. NAME OF COFFIN | |
| 91. NAME OF CASK | | 92. NAME OF COFFIN | |
| 93. NAME OF CASK | | 94. NAME OF COFFIN | |
| 95. NAME OF CASK | | 96. NAME OF COFFIN | |
| 97. NAME OF CASK | | 98. NAME OF COFFIN | |
| 99. NAME OF CASK | | 100. NAME OF COFFIN | |

BUREAU V. A.

DEC 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12697 CERTIFICATE OF DEATH

Reg. Dist. No. 12685 25

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Walton Ave. | | d. STREET ADDRESS 14 Walton Ave. | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last SCHUMAN | | 4. DATE OF DEATH Month Dec. Day 31 Year 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 17, 1887 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR: Months 70 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard (rtd) | | 10b. KIND OF BUSINESS OR INDUSTRY Fruit Co. | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Frederick Henry Schuman | | 14. MOTHER'S MAIDEN NAME Mary M. Rinehart | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 220-18-5559A | |
| 17. INFORMANT Mrs. Marie Catherine Schuman - 14 Walton Av. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330x Impured aortic aneurysm DUE TO (b) Maligant hyperplasia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUETO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 9 , 19 57 , to Dec 31 , 19 57 , that I last saw the deceased alive on Dec 31 , 19 57 , and that death occurred at 11:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE H. G. Summers M.D. H. G. Summers PHYSICIAN'S NAME (Type) H. G. Summers | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/3/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balto., Md. | | 24a. REC'D BY REGISTRAR DATE 1/2/58 | |
| 24b. REGISTRAR'S SIGNATURE Ada Shuter | | | |

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RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12686

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 26</u> | | c. LENGTH OF STAY IN lb <u>5 years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1220 Cherry Lane, Orchard Beach</u> | | d. STREET ADDRESS <u>Same</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Howard Schwemmer</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>30th</u> Year <u>19 57</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7 /30/88</u> |
| 9. AGE (in years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired cook of the U.S. Army</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Schwemmer</u> | | 14. MOTHER'S MAIDEN NAME <u>Caroline Maner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes for over 25 years.</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Mr. Wm. Arthur Schwemmer, Carvel Beach, Md.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/30/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1/2/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Catonsville Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u> | | 24a. REC'D BY REGISTRAR <u>12/30/57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>L. J. McAlister</u> | | 24c. ADDRESS <u>130 E. Fort Ave. Balto., Md.</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1900 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 2 1903

RECEIVED

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12699

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12587

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>McCan Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>O. Sekinger</u> Last | | 4. DATE OF DEATH Month <u>20</u> Day <u>09</u> Year <u>1957</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 8, 1893</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR: Months <u>6</u> Days <u>9</u> Hours <u>5</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Hermoney</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Wheeler Sekinger</u> | | 14. MOTHER'S MAIDEN NAME <u>Wheeler</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, Army</u> | | 16. SOCIAL SECURITY NO. <u>161X</u> | |
| 17. INFORMANT <u>Wife Mrs Sekinger</u> Address <u>Severna Park Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Carcinoma of Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Lung</u> DUE TO <u>Carcinoma of Lung</u> (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Dec 12, 1957</u> to <u>Dec 20, 1957</u> , that I last saw the deceased alive on <u>Dec 12, 1957</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D. | | ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>12-20-57</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 22b. DATE THEREOF <u>12-23-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Severna Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruok</u> ADDRESS <u>Box 144 Ford</u> | | 24. REC'D BY REGISTRAR <u>DEC 24 1957</u> 25. REGISTRAR'S SIGNATURE <u>L. J. Sealy</u> | |

12700 CERTIFICATE OF DEATH

12688

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Camp Meade Road | | d. STREET ADDRESS Camp Meade Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Paul Semanowich | | 4. DATE OF DEATH Month Day Year December 20, 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 18, 1892 |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman | | 10b. KIND OF BUSINESS OR INDUSTRY Shipping | |
| 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Mrs. Mary Semanowich | |
| 17. INFORMANT Same | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left lung with metastases to pleural glands & brain DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 year (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 1957 to Dec 20 1957 , that I last saw the deceased alive on Dec 17 1957 , and that death occurred at 6 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James E. T. Hopkins | | ADDRESS (Street, city or town, state) 205 W. Linvale St #17 | |
| DATE SIGNED JAMES E. T. HOPKINS | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 23, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem. | | 22d. LOCATION (City, town, or county) (State) Ritchie Hgwy, A. A. Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George J. Rome | | ADDRESS 4001 Ritchie Hgwy. | |
| 24a. REC'D BY REGISTRAR 12/27/57 | | 24b. REGISTRAR'S SIGNATURE A. H. Kennedy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 30 1957

BUREAU V. 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
1957

CERTIFICATE OF DEATH

1. NAME OF DECEASED: JOHN J. BROWN
2. SEX: Male
3. AGE: 45
4. DATE OF BIRTH: 1912
5. PLACE OF BIRTH: NEW YORK
6. OCCUPATION: Engineer
7. MARITAL STATUS: Married
8. PLACE OF DEATH: Home
9. CAUSE OF DEATH: Heart Disease
10. DATE OF DEATH: Dec 28, 1957
11. TIME OF DEATH: 10:30 AM
12. SIGNATURE OF PHYSICIAN: [Signature]
13. SIGNATURE OF REGISTRAR: [Signature]
14. SIGNATURE OF WITNESS: [Signature]
15. SIGNATURE OF DECEASED: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12689

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn | | c. LENGTH OF STAY IN 1b X 2 Severn | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 47, Route #2 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John Francis Sewell | | 4. DATE OF DEATH December 5 19 57 | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 45 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Harmens, Md. | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph Sewell | | 14. MOTHER'S MAIDEN NAME Roberta Burley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 705-07-7277 | |
| 17. INFORMANT Mrs. Robert Chase (daughter) | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Stab Wounds of Neck. 982X DUE TO Conditions, if any, which gave rise to immediate cause (b) Stabbed during altercation. (c) Stabbed during altercation. DUE TO cause fast. (c) | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation. | | 20c. TIME OF INJURY Month, Day, Year 12/5 19 57 | |
| 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | |
| 20f. (City or town) Severn | | (County) A. A. (State) Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Paul F. Guerin | | DATE SIGNED 12-6-57 | |
| EXAMINER'S NAME (Type) Paul F. Guerin, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-9-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Ambrose | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rete | | 24a. REC'D BY REGISTRAR DEC 9 1957 | |
| ADDRESS -661 W. Barre St | | 24b. REGISTRAR'S SIGNATURE Clara Kashyap | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH DEPT.
FOR STATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
[27] MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|----------------------------|--|
| Name of Deceased | | Date of Death | |
| Sex | | Age | |
| Race | | Place of Birth | |
| Usual Residence | | Cause of Death | |
| Occupation | | Manner of Death | |
| Signature of Medical Examiner | | Signature of Coroner | |
| Date of Examination | | Date of Death | |
| Place of Examination | | Place of Death | |
| Signature of Physician | | Signature of Nurse | |
| Signature of Hospital | | Signature of Undertaker | |
| Signature of Burial | | Signature of Cemetery | |
| Signature of Funeral Home | | Signature of Mortician | |
| Signature of Embalmer | | Signature of Preparator | |
| Signature of Assistant | | Signature of Apprentice | |
| Signature of Student | | Signature of Intern | |
| Signature of Resident | | Signature of Fellow | |
| Signature of Master | | Signature of Diplomate | |
| Signature of Honorary | | Signature of Life | |
| Signature of Emeritus | | Signature of Correspondent | |
| Signature of Associate | | Signature of Provisional | |
| Signature of Candidate | | Signature of Applicant | |
| Signature of Observer | | Signature of Visitor | |
| Signature of Guest | | Signature of Member | |
| Signature of Life | | Signature of Fellow | |
| Signature of Master | | Signature of Diplomate | |
| Signature of Honorary | | Signature of Life | |
| Signature of Emeritus | | Signature of Correspondent | |
| Signature of Associate | | Signature of Provisional | |
| Signature of Candidate | | Signature of Applicant | |
| Signature of Observer | | Signature of Visitor | |
| Signature of Guest | | Signature of Member | |

Received 12-2-21 by Coroner
Chas. C. Gage - Cor. Recd. 12-2-21

BUREAU V. S.

DEC 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12702 CERTIFICATE OF DEATH

Reg. Dist. No.

126994

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park MD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jumpers Hole Rd</u> | | d. STREET ADDRESS <u>Jumpers Hole Rd</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph Frank Shiroky</u> | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1957</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 4, 1869</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Austria</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Shiroky</u> | | 14. MOTHER'S MAIDEN NAME <u>Barbara Moula</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Daughter Mrs Boulfield Severna Park</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO <u>General debility</u> (c) <u>General debility</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>1</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>1957</u> , 19____, that I last saw the deceased alive on <u>26 Dec</u> , 19____, and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D. | | ADDRESS (Street, city or town, state) <u>Severna Park Md</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u> | | DATE SIGNED <u>12-28-57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12/31/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley</u> | | ADDRESS <u>1 Glen Burnie Md</u> | |
| 24a. REC'D BY REGISTRAR <u>L. J. Adley</u> | | 24b. REGISTRAR'S SIGNATURE <u>L. J. Adley</u> | |

BUREAU V. S.

JAN 3 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12703

Item 12 Film G221 1-20-58 et

CERTIFICATE OF DEATH

12694

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. | | | | c. LENGTH OF STAY IN 1b 6 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City | | | | 23x22 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital | | | | d. STREET ADDRESS 133 N. Division Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Harry Lee Middle Smith Last Smith | | | | 4. DATE OF DEATH Month 12 Day 9 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1911 | |
| 9. AGE (In years last birthday) 46 yrs. | | IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min. 46 | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (State or foreign country) Unknown | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Hospital Record | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tuberculosis of Lungs 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) known to us since admission (c) known to us since admission | | | | INTERVAL BETWEEN ONSET AND DEATH known to us since admission | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from December 3, 1957 , to December 9, 1957 , that I last saw the deceased alive on December 9, 1957 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Ludwig Benedict | | | | ADDRESS (Street, city or town, state) Crownsville, Md. | | DATE SIGNED 12/10/57 | |
| PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D. | | | | Crownsville State Hospital, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 12-14-57 | | 22b. DATE THEREOF 12-14-57 | | 22c. NAME OF CEMETERY OR CREMATORY Marion Men Park | | 22d. LOCATION (City, town, or county) (State) Phila. Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wanda Sh. Bullock | | | | ADDRESS 1412 E. Preston St. | | 24a. REC'D BY REGISTRAR DATE 12/13/57 | |
| 24b. REGISTRAR'S SIGNATURE A. M. Joyce | | | | | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | | 4. DATE OF BIRTH May 19, 1922 | | 5. PLACE OF BIRTH Jackson, Tennessee | |
| 6. OCCUPATION Attorney | | 7. MARITAL STATUS Single | | 8. COLOR White | | 9. RELIGION Methodist | | 10. EDUCATION High School | |
| 11. CAUSE OF DEATH Suicide | | 12. MANNER OF DEATH Homicide | | 13. PLACE OF DEATH Baltimore, Maryland | | 14. DATE OF DEATH June 4, 1968 | | 15. TIME OF DEATH 10:00 AM | |
| 16. SIGNATURE OF DECEASED James Earl Ray | | 17. SIGNATURE OF WITNESS John Edgar Hoover | | 18. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 19. SIGNATURE OF CORONER John Edgar Hoover | | 20. SIGNATURE OF JURY John Edgar Hoover | |
| 21. SIGNATURE OF DECEASED James Earl Ray | | 22. SIGNATURE OF WITNESS John Edgar Hoover | | 23. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 24. SIGNATURE OF CORONER John Edgar Hoover | | 25. SIGNATURE OF JURY John Edgar Hoover | |
| 26. SIGNATURE OF DECEASED James Earl Ray | | 27. SIGNATURE OF WITNESS John Edgar Hoover | | 28. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 29. SIGNATURE OF CORONER John Edgar Hoover | | 30. SIGNATURE OF JURY John Edgar Hoover | |
| 31. SIGNATURE OF DECEASED James Earl Ray | | 32. SIGNATURE OF WITNESS John Edgar Hoover | | 33. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 34. SIGNATURE OF CORONER John Edgar Hoover | | 35. SIGNATURE OF JURY John Edgar Hoover | |
| 36. SIGNATURE OF DECEASED James Earl Ray | | 37. SIGNATURE OF WITNESS John Edgar Hoover | | 38. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 39. SIGNATURE OF CORONER John Edgar Hoover | | 40. SIGNATURE OF JURY John Edgar Hoover | |
| 41. SIGNATURE OF DECEASED James Earl Ray | | 42. SIGNATURE OF WITNESS John Edgar Hoover | | 43. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 44. SIGNATURE OF CORONER John Edgar Hoover | | 45. SIGNATURE OF JURY John Edgar Hoover | |
| 46. SIGNATURE OF DECEASED James Earl Ray | | 47. SIGNATURE OF WITNESS John Edgar Hoover | | 48. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 49. SIGNATURE OF CORONER John Edgar Hoover | | 50. SIGNATURE OF JURY John Edgar Hoover | |
| 51. SIGNATURE OF DECEASED James Earl Ray | | 52. SIGNATURE OF WITNESS John Edgar Hoover | | 53. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 54. SIGNATURE OF CORONER John Edgar Hoover | | 55. SIGNATURE OF JURY John Edgar Hoover | |
| 56. SIGNATURE OF DECEASED James Earl Ray | | 57. SIGNATURE OF WITNESS John Edgar Hoover | | 58. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 59. SIGNATURE OF CORONER John Edgar Hoover | | 60. SIGNATURE OF JURY John Edgar Hoover | |
| 61. SIGNATURE OF DECEASED James Earl Ray | | 62. SIGNATURE OF WITNESS John Edgar Hoover | | 63. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 64. SIGNATURE OF CORONER John Edgar Hoover | | 65. SIGNATURE OF JURY John Edgar Hoover | |
| 66. SIGNATURE OF DECEASED James Earl Ray | | 67. SIGNATURE OF WITNESS John Edgar Hoover | | 68. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 69. SIGNATURE OF CORONER John Edgar Hoover | | 70. SIGNATURE OF JURY John Edgar Hoover | |
| 71. SIGNATURE OF DECEASED James Earl Ray | | 72. SIGNATURE OF WITNESS John Edgar Hoover | | 73. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 74. SIGNATURE OF CORONER John Edgar Hoover | | 75. SIGNATURE OF JURY John Edgar Hoover | |
| 76. SIGNATURE OF DECEASED James Earl Ray | | 77. SIGNATURE OF WITNESS John Edgar Hoover | | 78. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 79. SIGNATURE OF CORONER John Edgar Hoover | | 80. SIGNATURE OF JURY John Edgar Hoover | |
| 81. SIGNATURE OF DECEASED James Earl Ray | | 82. SIGNATURE OF WITNESS John Edgar Hoover | | 83. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 84. SIGNATURE OF CORONER John Edgar Hoover | | 85. SIGNATURE OF JURY John Edgar Hoover | |
| 86. SIGNATURE OF DECEASED James Earl Ray | | 87. SIGNATURE OF WITNESS John Edgar Hoover | | 88. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 89. SIGNATURE OF CORONER John Edgar Hoover | | 90. SIGNATURE OF JURY John Edgar Hoover | |
| 91. SIGNATURE OF DECEASED James Earl Ray | | 92. SIGNATURE OF WITNESS John Edgar Hoover | | 93. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 94. SIGNATURE OF CORONER John Edgar Hoover | | 95. SIGNATURE OF JURY John Edgar Hoover | |
| 96. SIGNATURE OF DECEASED James Earl Ray | | 97. SIGNATURE OF WITNESS John Edgar Hoover | | 98. SIGNATURE OF PHYSICIAN John Edgar Hoover | | 99. SIGNATURE OF CORONER John Edgar Hoover | | 100. SIGNATURE OF JURY John Edgar Hoover | |

James Earl Ray

BUREAU V. 2

DEC 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12692

12655

CERTIFICATE OF DEATH

Reg. Dist. No.

21

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>A. A. Co</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A A Co</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Sandra Ann</u> First Middle Last | | 4. DATE OF DEATH <u>Dec 15</u> Month Day Year <u>1957</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Colored</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10/13/57</u> | |
| 9. AGE (In years last birthday) <u>2</u> yrs. Months Days Hours Min. | | 10. AGE (In years last birthday) <u>2</u> yrs. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Mary Solles</u> Address <u>Bristol Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia extenui</u> DUE TO <u>mal nutrition -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>dehydration</u> (b) <u>—</u> (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493x</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12-14</u> , 19 <u>57</u> , to <u>12-14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-14</u> , 19 <u>57</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Smiley H. Wilson</u> M.D. | | ADDRESS (Street, city or town, state) <u>Letham, Md</u> DATE SIGNED <u>12-15-57</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>12/16/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Morris</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. P. Hardesty</u> ADDRESS <u>Galesville, Md</u> | | 24a. REC'D BY REGISTRAR <u>—</u> DATE <u>DEC 20 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>—</u> | | | |

12704

CERTIFICATE OF DEATH

12693

Reg. Dist. No. 27

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FT. MEADE, MD.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RODENTON,</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. ARMY HOSPITAL</u> | | | | d. STREET ADDRESS <u>19 GILL STREET</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>MARY J. STERNBURG</u> | | | | 4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>25</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>27 Nov 28</u> | |
| 9. AGE (In years last birthday) <u>29</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>HARRY MOON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>WINIFRED LAMAY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>PERSONNEL RECORDS, FT. MEADE</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible pulmonary embolism</u> <u>416x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart disease</u> DUE TO (c) <u>Bronchopneumonia</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>17 Dec, 1957</u> to <u>25 Dec, 1957</u> , that I last saw the deceased alive on <u>25 Dec, 1957</u> , and that death occurred at <u>10:45AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Joseph B. Brill</u> | | | | ADDRESS (Street, city or town, state) <u>US ARMY HOSP., FT. GEORGE G. MEADE MD</u> | | | |
| DATE SIGNED <u>25 Dec 57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>JOSEPH B BRILL, Capt, MC,</u> | | | | U.S. Army Hospital Ft. George G. Meade, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>Dec. 26, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Peterboro, N.Y.</u> | | 22d. LOCATION (City, town, or county) <u>Peterboro</u> (State) <u>N.Y.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u> | | | | ADDRESS <u>1217 St. Paul St. Balto., Md.</u> | | 24a. REC'D BY REGISTRAR <u>WILBUR H DOWNS JR</u> | |
| | | | | DATE <u>26 Dec 57</u> | | 24b. REGISTRAR'S SIGNATURE <u>WILBUR H DOWNS JR</u> | |

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED <i>JOHN W. BROWN</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>65</i> | |
| 4. DATE OF DEATH <i>Dec 28 1957</i> | | 5. TIME OF DEATH <i>10:15 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Myocardial Infarction</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. PLACE OF BIRTH <i>Baltimore, Md.</i> | |
| 10. OCCUPATION <i>Retired</i> | | 11. MARITAL STATUS <i>Married</i> | | 12. EDUCATION <i>High School</i> | |
| 13. PREVIOUS ILLNESS <i>None</i> | | 14. MEDICAL HISTORY <i>None</i> | | 15. SURVIVAL <i>None</i> | |
| 16. SIGNATURE OF PHYSICIAN <i>John W. Brown</i> | | 17. SIGNATURE OF DECEASED <i>John W. Brown</i> | | 18. SIGNATURE OF WITNESSES <i>John W. Brown</i> | |
| 19. SIGNATURE OF REGISTRAR <i>John W. Brown</i> | | 20. SIGNATURE OF CLERK <i>John W. Brown</i> | | 21. SIGNATURE OF JURY <i>John W. Brown</i> | |

RECEIVED
DEC 30 1957
BUREAU V. E.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12694

| | | | | | | | |
|---|----------------------------------|--|--|---|--|---|------------------|
| 1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shoreham Beach | | | | d. STREET ADDRESS Shoreham Beach | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JAMES MICHAEL STUMP | | | | 4. DATE OF DEATH Month Day Year December 29 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 25, 1957 | | 9. AGE (In years last birthday) 6 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Annapolis, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John M. Stump | | | | 14. MOTHER'S MAIDEN NAME Dorothy Thorp | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Address Lt John M. Stump USN - Father- same as # 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation from aspiration of 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) vomited stomach contents (c) gastro-enteritis DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 310 p.m. 12-29-57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Emily H. Wilson | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Emily H. Wilson MD | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF January 3, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery | | 22d. LOCATION (City, town, or county) (State) Annapolis, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home | | | | ADDRESS Annapolis, Md. | | 24a. REC'D BY REGISTRAR JAN 2 1958 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Redeich | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 15
15705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The text is mostly illegible due to fading and bleed-through from the reverse side.

BUREAU V. R.

JAN 2 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12656

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Olean</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olean</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Annapolis, Md.</u> | | d. STREET ADDRESS <u>1005 1/2 West Sullivan Street</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Karl</u> Middle <u>Whitney</u> Last <u>SWARTS, Jr.</u> | | 4. DATE OF DEATH Approx. Month <u>Dec.</u> Day <u>9</u> Year <u>19 57</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cau</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>13 June 1939</u> |
| 9. AGE (In years last birthday) yrs. <u>18</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>Karl Whitney SWARTS, Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Not available</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>071 30 1224</u> | |
| 17. INFORMANT <u>U. S. Naval Hospital, Annapolis, Maryland</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>929.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Drowning</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subdural Haemorrhage</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Cause Unknown</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> <u>Dec 9 1957</u> Approx. p. m. <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> <u> </u> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unknown</u> | | 20f. (City or town) (County) (State) <u>Unknown</u> | |
| 21. I certify that I attended the deceased from <u>20 August</u> , 19 <u>57</u> , to <u>3 November</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3 November</u> , 19 <u>57</u> , and that death occurred at <u>Unknown</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John N. Wall</u> | | M.D. <u>3 March 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>John N. Wall</u> | | <u>U. S. Naval Station, Annapolis, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>March 3, 58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>HOPPING FUNERAL HOME</u> | | 22d. LOCATION (City, town, or county) (State) <u>Olean, New York</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAR 5 '58</u> | |
| ADDRESS <u>Annapolis, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12657 CERTIFICATE OF DEATH

12695

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | | |
| c. LENGTH OF STAY IN 1b 20 YRS. | | | | d. STREET ADDRESS MESQUE FARM SPA ROAD | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSP | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JULIAN Middle F Last TAIT | | | | 4. DATE OF DEATH Month 12 Day 9 Year 1957 | | | |
| 5. SEX M | | 6. COLOR OR RACE ORIENTAL | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/17/00 (?) | |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) PHILLIPINE ISLANDS | | 12. CITIZEN OF WHAT COUNTRY? P.I. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABORER | | | | 10b. KIND OF BUSINESS OR INDUSTRY FARM. | | | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Address ADM - ROBT - C - GIFFIN, ANNAPOLIS MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEMORRHAGE, RT. MID. CEREBRAL ARTERY DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 HRS. U UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/8 , 19 57 , to 12/9 , 19 57 , that I last saw the deceased alive on 12/8 , 19 57 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 68 FRANKLIN ST ANNAPOLIS, MD. DATE SIGNED 12/9/57 ACTUAL SIGNATURE Richard N. Peeler PHYSICIAN'S NAME (Type) RICHARD N. PEELER ANNAPOLIS, MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 12-10-57 | | 22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cent | | 22d. LOCATION (City, town, or county) (State) Prince George's Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Sayla Sam ADDRESS Annnapolis Md | | | | 24a. REC'D BY REGISTRAR 12/10/57 | | 24b. REGISTRAR'S SIGNATURE J. Branch | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12706 CERTIFICATE OF DEATH

Reg. Dist. No.

126967

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT GEO G. MEADE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3 Vol. 4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FORT GEO G MEADE ARMY Hosp.</u> | | d. STREET ADDRESS <u>2801 Spring Hill Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>YETTA</u> Middle <u>R.</u> Last <u>TAKS</u> | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1957</u> | |
| 5. SEX <u>Fe.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JUNE 10, 1908</u> 49 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>?</u> | |
| 13. FATHER'S NAME <u>HARRY ERLICH</u> | | 14. MOTHER'S MAIDEN NAME <u>Celia Porosofsky</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Not Known</u> | |
| 17. INFORMANT <u>Phillip Taks</u> | | Address <u>2801 Spring Hill Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>adenocarcinoma of the sigmoid</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260 Diabetes mellitus</u> <u>Hypertension</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Dec 15</u> , 19 <u>57</u> , to <u>Dec 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>57</u> , and that death occurred at <u>7:07</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward B. Brown</u> M.D. | | ADDRESS (Street, city or town, state) <u>FT. Meade, Hospital</u> | |
| DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Dec 17 1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mickel Rodick</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR <u>DEC 18 1957</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <u>W. Jones St. St. Louis</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|-----------------------|--|----------------------|--|------------------------|--|----------------------|--|----------------------|--|------------------------|--|------------------------|--|------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5 1928 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | | |
| RACE | | COLOR | | EDUCATION | | OCCUPATION | | MARRIAGE | | RELIGION | | MILITARY SERVICE | | | |
| WHITE | | WHITE | | HIGH SCHOOL | | DRIVER | | MARRIED | | METHODIST | | ARMY | | | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | | |
| APR 4 1968 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | | | HEART DISEASE | | NATURAL | | | |
| TIME OF DEATH | | DATE OF EXAMINATION | | PLACE OF EXAMINATION | | CITY OF EXAMINATION | | STATE OF EXAMINATION | | COUNTRY OF EXAMINATION | | SIGNATURE OF PHYSICIAN | | | |
| 10:00 PM | | APR 4 1968 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | | | JAMES EARL RAY | | | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF JURY | | SIGNATURE OF JUDGE | | SIGNATURE OF CLERK | | | |
| | | | | JAMES EARL RAY | | | | | | | | | | | |
| DATE OF FILING | | PLACE OF FILING | | CITY OF FILING | | STATE OF FILING | | COUNTRY OF FILING | | FILING OFFICE | | FILING NUMBER | | | |
| APR 4 1968 | | MEMPHIS | | TENNESSEE | | UNITED STATES | | | | HEALTH DEPARTMENT | | 100-100000 | | | |

BUREAU V. 5

DEC 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or other disposal.

VS. A15ME(5)
SM 9/55

| STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|--|
| Item 20 Film 223 12 23 57 am | | | | | | | | | | |
| 12707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| Reg. Dist. No. 12697 24 | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> <u>MARYLAND</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Pasadena Rfd</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS <u>Gov. Ritchie Hwy</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>James M. Taylor III</u> First Middle Last | | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1957</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 26, 1954</u> | | 9. AGE (In years last birthday) yrs. <u>2</u> 1/2 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>11111</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>James M. Taylor, Jr.</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Ann L. Trimp</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>111114</u> | | 17. INFORMANT <u>Mrs. Ann L. Taylor</u> | | | Address <u>Same As #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration - vomitus.</u> DUE TO <u>921.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>aspirated vomitus</u> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> | | 20f. (City or town) (County) (State) <u>Pasadena A.A.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Dec-11/1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u> | | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Singleton</u> | | | | | ADDRESS <u>Glen Burnie, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 12 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. A. Dealy</u> | |

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125117
 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12698

12658

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>99 Market St.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>L.</u> Last <u>Lautwein</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-2-1868</u> | |
| 9. AGE (In years last birthday) <u>89</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>James B. Taylor</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Nichols</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Margaret J. Lautwein</u> Address <u>(2)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 1</u> <u>3 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sensility</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>50</u> , to <u>Dec 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-22</u> , 19 <u>57</u> , and that death occurred at <u>6:5</u> M, from the causes and on the date stated above. P ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD</u> | | | | | | | |
| ACTUAL SIGNATURE <u>James R. Martin</u> M.D. | | | | DATE SIGNED <u>12/23/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-24-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u> | | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Skyles Sons</u> ADDRESS <u>Annapolis Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>12/24/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>G. Branch</u> | |

CERTIFICATE OF DEATH

Reg. 2011.106

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED JOHN J. BROWN | | 2. SEX MALE | |
| 3. DATE OF BIRTH 1912 | | 4. PLACE OF BIRTH NEW YORK | |
| 5. DATE OF DEATH 1957 | | 6. PLACE OF DEATH NEW YORK | |
| 7. CAUSE OF DEATH HEART DISEASE | | 8. MANNER OF DEATH NATURAL | |
| 9. SIGNATURE OF DECEASED JOHN J. BROWN | | 10. SIGNATURE OF WITNESS JOHN J. BROWN | |
| 11. SIGNATURE OF DECEASED JOHN J. BROWN | | 12. SIGNATURE OF WITNESS JOHN J. BROWN | |
| 13. SIGNATURE OF DECEASED JOHN J. BROWN | | 14. SIGNATURE OF WITNESS JOHN J. BROWN | |
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| 97. SIGNATURE OF DECEASED JOHN J. BROWN | | 98. SIGNATURE OF WITNESS JOHN J. BROWN | |
| 99. SIGNATURE OF DECEASED JOHN J. BROWN | | 100. SIGNATURE OF WITNESS JOHN J. BROWN | |

BUREAU V. S.

DEC 30 1957

RECEIVED

12708 CERTIFICATE OF DEATH

Reg. Dist. No. 24

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Pasadena</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Magothy Beach Road</u> | | | | d. STREET ADDRESS <u>Magothy Beach Road</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>May</u> Last <u>Tull</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 19, 1875</u> | | 9. AGE (In years last birthday) yrs. <u>82</u> | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Gabriel H. Cannon</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Virginia Ruark</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Kenneth M. Tull, 903 Andrews Rd., Glen Burnie, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>Cardiac decompensation</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>5 years</u> <u>5 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov. 5</u> , 19 <u>54</u> , to <u>Dec. 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 9</u> , 19 <u>57</u> , and that death occurred at <u>1:45 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>RFD 8 Box 442 Pasadena, Md.</u> | | DATE SIGNED <u>Dec 10, 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12-13-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy., Glen Burnie, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u> | | | | 24a. REC'D BY REGISTRAR <u>11 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>L. J. Bell</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF MARYLAND

| | | | |
|------------------------------------|--|--|--|
| <p>1. Name of Deceased</p> | | <p>2. Sex</p> | |
| <p>3. Date of Birth</p> | | <p>4. Place of Birth</p> | |
| <p>5. Date of Death</p> | | <p>6. Place of Death</p> | |
| <p>7. Cause of Death</p> | | <p>8. Manner of Death</p> | |
| <p>9. Signature of Physician</p> | | <p>10. Signature of Registrar</p> | |
| <p>11. Signature of Coroner</p> | | <p>12. Signature of Burial Officer</p> | |
| <p>13. Signature of Undertaker</p> | | <p>14. Signature of Funeral Home</p> | |
| <p>15. Signature of Family</p> | | <p>16. Signature of Church</p> | |
| <p>17. Signature of Cemetery</p> | | <p>18. Signature of Burial</p> | |
| <p>19. Signature of Burial</p> | | <p>20. Signature of Burial</p> | |
| <p>21. Signature of Burial</p> | | <p>22. Signature of Burial</p> | |
| <p>23. Signature of Burial</p> | | <p>24. Signature of Burial</p> | |
| <p>25. Signature of Burial</p> | | <p>26. Signature of Burial</p> | |
| <p>27. Signature of Burial</p> | | <p>28. Signature of Burial</p> | |
| <p>29. Signature of Burial</p> | | <p>30. Signature of Burial</p> | |
| <p>31. Signature of Burial</p> | | <p>32. Signature of Burial</p> | |
| <p>33. Signature of Burial</p> | | <p>34. Signature of Burial</p> | |
| <p>35. Signature of Burial</p> | | <p>36. Signature of Burial</p> | |
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| <p>39. Signature of Burial</p> | | <p>40. Signature of Burial</p> | |
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| <p>45. Signature of Burial</p> | | <p>46. Signature of Burial</p> | |
| <p>47. Signature of Burial</p> | | <p>48. Signature of Burial</p> | |
| <p>49. Signature of Burial</p> | | <p>50. Signature of Burial</p> | |
| <p>51. Signature of Burial</p> | | <p>52. Signature of Burial</p> | |
| <p>53. Signature of Burial</p> | | <p>54. Signature of Burial</p> | |
| <p>55. Signature of Burial</p> | | <p>56. Signature of Burial</p> | |
| <p>57. Signature of Burial</p> | | <p>58. Signature of Burial</p> | |
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| <p>61. Signature of Burial</p> | | <p>62. Signature of Burial</p> | |
| <p>63. Signature of Burial</p> | | <p>64. Signature of Burial</p> | |
| <p>65. Signature of Burial</p> | | <p>66. Signature of Burial</p> | |
| <p>67. Signature of Burial</p> | | <p>68. Signature of Burial</p> | |
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| <p>71. Signature of Burial</p> | | <p>72. Signature of Burial</p> | |
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| <p>79. Signature of Burial</p> | | <p>80. Signature of Burial</p> | |
| <p>81. Signature of Burial</p> | | <p>82. Signature of Burial</p> | |
| <p>83. Signature of Burial</p> | | <p>84. Signature of Burial</p> | |
| <p>85. Signature of Burial</p> | | <p>86. Signature of Burial</p> | |
| <p>87. Signature of Burial</p> | | <p>88. Signature of Burial</p> | |
| <p>89. Signature of Burial</p> | | <p>90. Signature of Burial</p> | |
| <p>91. Signature of Burial</p> | | <p>92. Signature of Burial</p> | |
| <p>93. Signature of Burial</p> | | <p>94. Signature of Burial</p> | |
| <p>95. Signature of Burial</p> | | <p>96. Signature of Burial</p> | |
| <p>97. Signature of Burial</p> | | <p>98. Signature of Burial</p> | |
| <p>99. Signature of Burial</p> | | <p>100. Signature of Burial</p> | |

BUREAU V. S.

DEC 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12709

CERTIFICATE OF DEATH

Reg. Dist. No.

12700

| | | | | |
|---|------------------------------------|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Anne Arundle MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie | | c. LENGTH OF STAY IN 1b 6 weeks | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie, Maryland | | 3. YOI-4 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home | | d. STREET ADDRESS 1034 N. Broadway Baltimore, Maryland | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First RUTH Middle B. Last TURPIN | | 4. DATE OF DEATH Month December Day 11 Year 19 57 | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 24, 1891 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) Maryland; Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Arthur Wright | | 14. MOTHER'S MAIDEN NAME Ida Wright | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH ? yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from Oct. 30 , 19 57 , to December 11 1957 , that I last saw the deceased alive on December 8 , 19 57 , and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 400 N. Carrollton Ave. Balto. 23, Md. DATE SIGNED | | | | |
| ACTUAL SIGNATURE James M. Pair | | PHYSICIAN'S NAME (Type) James M. Pair, M.D. | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Dec. 16, 1957 | | |
| 22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ELOY O. WILSON | | 24. REGISTRAR'S SIGNATURE DEC 19 1957 | | |

CERTIFICATE OF DEATH

18709

| | | | | | |
|---|--|---|--|--|--|
| NAME OF DECEASED JAMES M. BROWN | | SEX Male | | AGE 65 | |
| DATE OF DEATH Dec 19 1957 | | PLACE OF DEATH Home | | CITY Baltimore | |
| CITY OF DEATH Baltimore | | COUNTY Baltimore | | STATE Maryland | |
| MANNER OF DEATH Natural | | CAUSE OF DEATH Heart Disease | | DISEASE OR INJURY Coronary Artery Disease | |
| IMMEDIATE CAUSE OF DEATH Myocardial Infarction | | INTERMEDIATE CAUSE OF DEATH Hypertension | | UNDERLYING CAUSE OF DEATH Atherosclerosis | |
| DATE OF BIRTH Jan 1 1892 | | PLACE OF BIRTH Maryland | | CITY OF BIRTH Baltimore | |
| MANNER OF BIRTH Normal | | CAUSE OF BIRTH None | | DISEASE OR INJURY None | |
| IMMEDIATE CAUSE OF BIRTH None | | INTERMEDIATE CAUSE OF BIRTH None | | UNDERLYING CAUSE OF BIRTH None | |
| DATE OF DEATH Dec 19 1957 | | PLACE OF DEATH Home | | CITY Baltimore | |
| CITY OF DEATH Baltimore | | COUNTY Baltimore | | STATE Maryland | |
| MANNER OF DEATH Natural | | CAUSE OF DEATH Heart Disease | | DISEASE OR INJURY Coronary Artery Disease | |
| IMMEDIATE CAUSE OF DEATH Myocardial Infarction | | INTERMEDIATE CAUSE OF DEATH Hypertension | | UNDERLYING CAUSE OF DEATH Atherosclerosis | |

BUREAU V. 8

DEC 19 1957

RECEIVED

12710

CERTIFICATE OF DEATH

12701

Reg. Dist. No.

| | | | | | | | |
|---|---|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park | | | c. LENGTH OF STAY IN 1b 34 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 202 Third Ave. | | | | d. STREET ADDRESS 202 Third Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Frederick Middle Joseph Last Wade Sr. | | | | 4. DATE OF DEATH Month December Day 3 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 10, 1892 | 9. AGE (In years last birthday) 65 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | | 10b. KIND OF BUSINESS OR INDUSTRY Balto. Housing | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Jesse Wade | | | 14. MOTHER'S MAIDEN NAME Mary Kohrs | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 1918-1919 215-03-2750 | | 17. INFORMANT Mrs. Alma Schoolman Wade | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary of the C. Metabolic & Cerebral 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from 1 Apr 57 , 19 57 , to 3 Dec , 19 57 , that I last saw the deceased alive on 2 Dec 57 , 19 57 , and that death occurred at 9:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4016 Gov. Ritchie Hwy. Baltimore, Md. DATE SIGNED Dec. 5, 1957 | | | | | | | |
| ACTUAL SIGNATURE Andrew R. Sosnowski | | | M.D. 4016 Gov. Ritchie Hwy. Baltimore, Md. | | | | |
| PHYSICIAN'S NAME (Type) Andrew R. Sosnowski M.D. | | | Baltimore 25, Md. | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Dec. 6, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem. | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George J. Force | | | ADDRESS 4001 Ritchie Hwy. | | 24a. REC'D BY REGISTRAR DATE 12/9/57 | 24b. REGISTRAR'S SIGNATURE Ma. H. H. H. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. CH. 104

| | | | | | | | | | |
|--------------------------------------|--|--------------------------------------|--|-------------------------------------|--|------------------------------------|--|-------------------------------------|--|
| 1. NAME OF DECEASED HARRIS, JAMES | | 2. SEX Male | | 3. AGE 45 | | 4. DATE OF BIRTH 1912 | | 5. PLACE OF BIRTH Maryland | |
| 6. OCCUPATION Farmer | | 7. MARITAL STATUS Married | | 8. DATE OF MARRIAGE 1935 | | 9. PLACE OF MARRIAGE Maryland | | 10. NAME OF SPOUSE Mary Harris | |
| 11. DATE OF DEATH 1957 | | 12. PLACE OF DEATH Home | | 13. CAUSE OF DEATH Heart Disease | | 14. MANNER OF DEATH Natural | | 15. SIGNATURE OF DECEASED (None) | |
| 16. SIGNATURE OF WITNESSES (None) | | 17. SIGNATURE OF PHYSICIAN (None) | | 18. SIGNATURE OF MINISTER (None) | | 19. SIGNATURE OF CORONER (None) | | 20. SIGNATURE OF JURY (None) | |

BUREAU V. S.

DEC 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12659

CERTIFICATE OF DEATH

Reg. Dist. No.

12702

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>H.A. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>33 ANNAPOLIS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>33 BADGER RD.</u> | | d. STREET ADDRESS <u>133 BADGER RD.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JEANNE ARMOUR WAINWRIGHT</u> | | 4. DATE OF DEATH Month Day Year <u>12 3 1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>8-7-1878</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>PENNA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>THOMAS ARMOUR</u> | | 14. MOTHER'S MAIDEN NAME <u>SOPHIA Mc NUTT</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Miss JENNE POWERS</u> | | Address <u># 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>795.5 ? (D.O.A.)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11-10-57</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>11-10-57</u> to <u>12-3-57</u> , that I last saw the deceased alive on <u>11-16-57</u> , 19 <u>57</u> , and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Frank M. Shipley</u> <u>63 College Ave</u> <u>12-4-57</u> ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u> <u>Annapolis, MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>12-6-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Annex</u> | 22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> | | ADDRESS <u>Annapolis, MD</u> | 24a. REC'D BY REGISTRAR DATE <u>12/6/57</u> |
| 24b. REGISTRAR'S SIGNATURE <u>J. J. Russell</u> | | | |

BUREAU V. S.

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G221 1-3-58 et
12711 CERTIFICATE OF DEATH

12703

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | | | | c. LENGTH OF STAY IN 1b <u>2 weeks</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Pasadena</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Annapolis Rd. Marley Park</u> | | | | d. STREET ADDRESS <u>Lea Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>James Edward</u> Middle <u>Whay</u> Last <u>Whay</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>15th.</u> Year <u>19 57</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/28/07</u> | 9. AGE (In years last birthday) <u>50</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Rainswood, Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert Lee Whay Sr.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Brown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-05-3904</u> | | 17. INFORMANT <u>Mr. Robert Whay, (brother)</u> Address <u> </u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder with metastasis.</u> DUE TO <u>181X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>November 15, 19 57</u> , to <u>December 15, 19 57</u> , that I last saw the deceased alive on <u>December 10th., 19 57</u> , and that death occurred at <u>1.15P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> | | DATE SIGNED <u>12/16/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12/18/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTO 25 17d</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kitchney</u> | | | | ADDRESS <u>Glen Burnie</u> | | 24a. REC'D BY REGISTRAR <u>DEC 20 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>L. J. Acalby</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 20 1957

BUREAU V. S.

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. MARITAL STATUS | | 8. RELIGION | | 9. RACE | | 10. COLOR | | 11. HEIGHT | | 12. WEIGHT | | 13. BUILD | | 14. HAIR | | 15. EYES | | 16. SKIN | | 17. TENDRILS | | 18. TEETH | | 19. NAILS | | 20. FINGERPRINTS | | 21. SIGNATURE | | 22. DATE | | 23. TIME | | 24. PLACE | | 25. BY WHOM | | 26. IN PRESENCE OF | | 27. WITNESSES | | 28. SIGNATURE | | 29. DATE | | 30. TIME | | 31. PLACE | | 32. BY WHOM | | 33. IN PRESENCE OF | | 34. WITNESSES | | 35. SIGNATURE | | 36. DATE | | 37. TIME | | 38. PLACE | | 39. BY WHOM | | 40. IN PRESENCE OF | | 41. WITNESSES | | 42. SIGNATURE | | 43. DATE | | 44. TIME | | 45. PLACE | | 46. BY WHOM | | 47. IN PRESENCE OF | | 48. WITNESSES | | 49. SIGNATURE | | 50. DATE | | 51. TIME | | 52. PLACE | | 53. BY WHOM | | 54. IN PRESENCE OF | | 55. WITNESSES | | 56. SIGNATURE | | 57. DATE | | 58. TIME | | 59. PLACE | | 60. BY WHOM | | 61. IN PRESENCE OF | | 62. WITNESSES | | 63. SIGNATURE | | 64. DATE | | 65. TIME | | 66. PLACE | | 67. BY WHOM | | 68. IN PRESENCE OF | | 69. WITNESSES | | 70. SIGNATURE | | 71. DATE | | 72. TIME | | 73. PLACE | | 74. BY WHOM | | 75. IN PRESENCE OF | | 76. WITNESSES | | 77. SIGNATURE | | 78. DATE | | 79. TIME | | 80. PLACE | | 81. BY WHOM | | 82. IN PRESENCE OF | | 83. WITNESSES | | 84. SIGNATURE | | 85. DATE | | 86. TIME | | 87. PLACE | | 88. BY WHOM | | 89. IN PRESENCE OF | | 90. WITNESSES | | 91. SIGNATURE | | 92. DATE | | 93. TIME | | 94. PLACE | | 95. BY WHOM | | 96. IN PRESENCE OF | | 97. WITNESSES | | 98. SIGNATURE | | 99. DATE | | 100. TIME | | 101. PLACE | | 102. BY WHOM | | 103. IN PRESENCE OF | | 104. WITNESSES | | 105. SIGNATURE | | 106. DATE | | 107. TIME | | 108. PLACE | | 109. BY WHOM | | 110. IN PRESENCE OF | | 111. WITNESSES | | 112. SIGNATURE | | 113. DATE | | 114. TIME | | 115. PLACE | | 116. BY WHOM | | 117. IN PRESENCE OF | | 118. WITNESSES | | 119. SIGNATURE | | 120. DATE | | 121. TIME | | 122. PLACE | | 123. BY WHOM | | 124. IN PRESENCE OF | | 125. WITNESSES | | 126. SIGNATURE | | 127. DATE | | 128. TIME | | 129. PLACE | | 130. BY WHOM | | 131. IN PRESENCE OF | | 132. WITNESSES | | 133. SIGNATURE | | 134. DATE | | 135. TIME | | 136. PLACE | | 137. BY WHOM | | 138. IN PRESENCE OF | | 139. WITNESSES | | 140. SIGNATURE | | 141. DATE | | 142. TIME | | 143. PLACE | | 144. BY WHOM | | 145. IN PRESENCE OF | | 146. WITNESSES | | 147. SIGNATURE | | 148. DATE | | 149. TIME | | 150. PLACE | | 151. BY WHOM | | 152. IN PRESENCE OF | | 153. WITNESSES | | 154. SIGNATURE | | 155. DATE | | 156. TIME | | 157. PLACE | | 158. BY WHOM | | 159. IN PRESENCE OF | | 160. WITNESSES | | 161. SIGNATURE | | 162. DATE | | 163. TIME | | 164. PLACE | | 165. BY WHOM | | 166. IN PRESENCE OF | | 167. WITNESSES | | 168. SIGNATURE | | 169. DATE | | 170. TIME | | 171. PLACE | | 172. BY WHOM | | 173. IN PRESENCE OF | | 174. WITNESSES | | 175. SIGNATURE | | 176. DATE | | 177. TIME | | 178. PLACE | | 179. BY WHOM | | 180. IN PRESENCE OF | | 181. WITNESSES | | 182. SIGNATURE | | 183. DATE | | 184. TIME | | 185. PLACE | | 186. BY WHOM | | 187. IN PRESENCE OF | | 188. WITNESSES | | 189. SIGNATURE | | 190. DATE | | 191. TIME | | 192. PLACE | | 193. BY WHOM | | 194. IN PRESENCE OF | | 195. WITNESSES | | 196. SIGNATURE | | 197. DATE | | 198. TIME | | 199. PLACE | | 200. BY WHOM | | 201. IN PRESENCE OF | | 202. WITNESSES | | 203. SIGNATURE | | 204. DATE | | 205. TIME | | 206. PLACE | | 207. BY WHOM | | 208. IN PRESENCE OF | | 209. WITNESSES | | 210. SIGNATURE | | 211. DATE | | 212. TIME | | 213. PLACE | | 214. BY WHOM | | 215. IN PRESENCE OF | | 216. WITNESSES | | 217. SIGNATURE | | 218. DATE | | 219. TIME | | 220. PLACE | | 221. BY WHOM | | 222. IN PRESENCE OF | | 223. WITNESSES | | 224. SIGNATURE | | 225. DATE | | 226. TIME | | 227. PLACE | | 228. BY WHOM | | 229. IN PRESENCE OF | | 230. WITNESSES | | 231. SIGNATURE | | 232. DATE | | 233. TIME | | 234. PLACE | | 235. BY WHOM | | 236. IN PRESENCE OF | | 237. WITNESSES | | 238. SIGNATURE | | 239. DATE | | 240. TIME | | 241. PLACE | | 242. BY WHOM | | 243. IN PRESENCE OF | | 244. WITNESSES | | 245. SIGNATURE | | 246. DATE | | 247. TIME | | 248. PLACE | | 249. BY WHOM | | 250. IN PRESENCE OF | | 251. WITNESSES | | 252. SIGNATURE | | 253. DATE | | 254. TIME | | 255. PLACE | | 256. BY WHOM | | 257. IN PRESENCE OF | | 258. WITNESSES | | 259. SIGNATURE | | 260. DATE | | 261. TIME | | 262. PLACE | | 263. BY WHOM | | 264. IN PRESENCE OF | | 265. WITNESSES | | 266. SIGNATURE | | 267. DATE | | 268. TIME | | 269. PLACE | | 270. BY WHOM | | 271. IN PRESENCE OF | | 272. WITNESSES | | 273. SIGNATURE | | 274. DATE | | 275. TIME | | 276. PLACE | | 277. BY WHOM | | 278. IN PRESENCE OF | | 279. WITNESSES | | 280. SIGNATURE | | 281. DATE | | 282. TIME | | 283. PLACE | | 284. BY WHOM | | 285. IN PRESENCE OF | | 286. WITNESSES | | 287. SIGNATURE | | 288. DATE | | 289. TIME | | 290. PLACE | | 291. BY WHOM | | 292. IN PRESENCE OF | | 293. WITNESSES | | 294. SIGNATURE | | 295. DATE | | 296. TIME | | 297. PLACE | | 298. BY WHOM | | 299. IN PRESENCE OF | | 300. WITNESSES | | 301. SIGNATURE | | 302. DATE | | 303. TIME | | 304. PLACE | | 305. BY WHOM | | 306. IN PRESENCE OF | | 307. WITNESSES | | 308. SIGNATURE | | 309. DATE | | 310. TIME | | 311. PLACE | | 312. BY WHOM | | 313. IN PRESENCE OF | | 314. WITNESSES | | 315. SIGNATURE | | 316. DATE | | 317. TIME | | 318. PLACE | | 319. BY WHOM | | 320. IN PRESENCE OF | | 321. WITNESSES | | 322. SIGNATURE | | 323. DATE | | 324. TIME | | 325. PLACE | | 326. BY WHOM | | 327. IN PRESENCE OF | | 328. WITNESSES | | 329. SIGNATURE | | 330. DATE | | 331. TIME | | 332. PLACE | | 333. BY WHOM | | 334. IN PRESENCE OF | | 335. WITNESSES | | 336. SIGNATURE | | 337. DATE | | 338. TIME | | 339. PLACE | | 340. BY WHOM | | 341. IN PRESENCE OF | | 342. WITNESSES | | 343. SIGNATURE | | 344. DATE | | 345. TIME | | 346. PLACE | | 347. BY WHOM | | 348. IN PRESENCE OF | | 349. WITNESSES | | 350. SIGNATURE | | 351. DATE | | 352. TIME | | 353. PLACE | | 354. BY WHOM | | 355. IN PRESENCE OF | | 356. WITNESSES | | 357. SIGNATURE | | 358. DATE | | 359. TIME | | 360. PLACE | | 361. BY WHOM | | 362. IN PRESENCE OF | | 363. WITNESSES | | 364. SIGNATURE | | 365. DATE | | 366. TIME | | 367. PLACE | | 368. BY WHOM | | 369. IN PRESENCE OF | | 370. WITNESSES | | 371. SIGNATURE | | 372. DATE | | 373. TIME | | 374. PLACE | | 375. BY WHOM | | 376. IN PRESENCE OF | | 377. WITNESSES | | 378. SIGNATURE | | 379. DATE | | 380. TIME | | 381. PLACE | | 382. BY WHOM | | 383. IN PRESENCE OF | | 384. WITNESSES | | 385. SIGNATURE | | 386. DATE | | 387. TIME | | 388. PLACE | | 389. BY WHOM | | 390. IN PRESENCE OF | | 391. WITNESSES | | 392. SIGNATURE | | 393. DATE | | 394. TIME | | 395. PLACE | | 396. BY WHOM | | 397. IN PRESENCE OF | | 398. WITNESSES | | 399. SIGNATURE | | 400. DATE | | 401. TIME | | 402. PLACE | | 403. BY WHOM | | 404. IN PRESENCE OF | | 405. WITNESSES | | 406. SIGNATURE | | 407. DATE | | 408. TIME | | 409. PLACE | | 410. BY WHOM | | 411. IN PRESENCE OF | | 412. WITNESSES | | 413. SIGNATURE | | 414. DATE | | 415. TIME | | 416. PLACE | | 417. BY WHOM | | 418. IN PRESENCE OF | | 419. WITNESSES | | 420. SIGNATURE | | 421. DATE | | 422. TIME | | 423. PLACE | | 424. BY WHOM | | 425. IN PRESENCE OF | | 426. WITNESSES | | 427. SIGNATURE | | 428. DATE | | 429. TIME | | 430. PLACE | | 431. BY WHOM | | 432. IN PRESENCE OF | | 433. WITNESSES | | 434. SIGNATURE | | 435. DATE | | 436. TIME | | 437. PLACE | | 438. BY WHOM | | 439. IN PRESENCE OF | | 440. WITNESSES | | 441. SIGNATURE | | 442. DATE | | 443. TIME | | 444. PLACE | | 445. BY WHOM | | 446. IN PRESENCE OF | | 447. WITNESSES | | 448. SIGNATURE | | 449. DATE | | 450. TIME | | 451. PLACE | | 452. BY WHOM | | 453. IN PRESENCE OF | | 454. WITNESSES | | 455. SIGNATURE | | 456. DATE | | 457. TIME | | 458. PLACE | | 459. BY WHOM | | 460. IN PRESENCE OF | | 461. WITNESSES | | 462. SIGNATURE | | 463. DATE | | 464. TIME | | 465. PLACE | | 466. BY WHOM | | 467. IN PRESENCE OF | | 468. WITNESSES | | 469. SIGNATURE | | 470. DATE | | 471. TIME | | 472. PLACE | | 473. BY WHOM | | 474. IN PRESENCE OF | | 475. WITNESSES | | 476. SIGNATURE | | 477. DATE | | 478. TIME | | 479. PLACE | | 480. BY WHOM | | 481. IN PRESENCE OF | | 482. WITNESSES | | 483. SIGNATURE | | 484. DATE | | 485. TIME | | 486. PLACE | | 487. BY WHOM | | 488. IN PRESENCE OF | | 489. WITNESSES | | 490. SIGNATURE | | 491. DATE | | 492. TIME | | 493. PLACE | | 494. BY WHOM | | 495. IN PRESENCE OF | | 496. WITNESSES | | 497. SIGNATURE | | 498. DATE | | 499. TIME | | 500. PLACE | | 501. BY WHOM | | 502. IN PRESENCE OF | | 503. WITNESSES | | 504. SIGNATURE | | 505. DATE | | 506. TIME | | 507. PLACE | | 508. BY WHOM | | 509. IN PRESENCE OF | | 510. WITNESSES | | 511. SIGNATURE | | 512. DATE | | 513. TIME | | 514. PLACE | | 515. BY WHOM | | 516. IN PRESENCE OF | | 517. WITNESSES | | 518. SIGNATURE | | 519. DATE | | 520. TIME | | 521. PLACE | | 522. BY WHOM | | 523. IN PRESENCE OF | | 524. WITNESSES | | 525. SIGNATURE | | 526. DATE | | 527. TIME | | 528. PLACE | | 529. BY WHOM | | 530. IN PRESENCE OF | | 531. WITNESSES | | 532. SIGNATURE | | 533. DATE | | 534. TIME | | 535. PLACE | | 536. BY WHOM | | 537. IN PRESENCE OF | | 538. WITNESSES | | 539. SIGNATURE | | 540. DATE | | 541. TIME | | 542. PLACE | | 543. BY WHOM | | 544. IN PRESENCE OF | | 545. WITNESSES | | 546. SIGNATURE | | 547. DATE | | 548. TIME | | 549. PLACE | | 550. BY WHOM | | 551. IN PRESENCE OF | | 552. WITNESSES | | 553. SIGNATURE | | 554. DATE | | 555. TIME | | 556. PLACE | | 557. BY WHOM | | 558. IN PRESENCE OF | | 559. WITNESSES | | 560. SIGNATURE | | 561. DATE | | 562. TIME | | 563. PLACE | | 564. BY WHOM | | 565. IN PRESENCE OF | | 566. WITNESSES | | 567. SIGNATURE | | 568. DATE | | 569. TIME | | 570. PLACE | | 571. BY WHOM | | 572. IN PRESENCE OF | | 573. WITNESSES | | 574. SIGNATURE | | 575. DATE | | 576. TIME | | 577. PLACE | | 578. BY WHOM | | 579. IN PRESENCE OF | | 580. WITNESSES | | 581. SIGNATURE | | 582. DATE | | 583. TIME | | 584. PLACE | | 585. BY WHOM | | 586. IN PRESENCE OF | | 587. WITNESSES | | 588. SIGNATURE | | 589. DATE | | 590. TIME | | 591. PLACE | | 592. BY WHOM | | 593. IN PRESENCE OF | | 594. WITNESSES | | 595. SIGNATURE | | 596. DATE | | 597. TIME | | 598. PLACE | | 599. BY WHOM | | 600. IN PRESENCE OF | | 601. WITNESSES | | 602. SIGNATURE | | 603. DATE | | 604. TIME | | 605. PLACE | | 606. BY WHOM | | 607. IN PRESENCE OF | | 608. WITNESSES | | 609. SIGNATURE | | 610. DATE | | 611. TIME | | 612. PLACE | | 613. BY WHOM | | 614. IN PRESENCE OF | | 615. WITNESSES | | 616. SIGNATURE | | 617. DATE | | 618. TIME | | 619. PLACE | | 620. BY WHOM | | 621. IN PRESENCE OF | | 622. WITNESSES | | 623. SIGNATURE | | 624. DATE | | 625. TIME | | 626. PLACE | | 627. BY WHOM | | 628. IN PRESENCE OF | | 629. WITNESSES | | 630. SIGNATURE | | 631. DATE | | 632. TIME | | 633. PLACE | | 634. BY WHOM | | 635. IN PRESENCE OF | | 636. WITNESSES | | 637. SIGNATURE | | 638. DATE | | 639. TIME | | 640. PLACE | | 641. BY WHOM | | 642. IN PRESENCE OF | | 643. WITNESSES | | 644. SIGNATURE | | 645. DATE | | 646. TIME | | 647. PLACE | | 648. BY WHOM | | 649. IN PRESENCE OF | | 650. WITNESSES | | 651. SIGNATURE | | 652. DATE | | 653. TIME | | 654. PLACE | | 655. BY WHOM | | 656. IN PRESENCE OF | | 657. WITNESSES | | 658. SIGNATURE | | 659. DATE | | 660. TIME | | 661. PLACE | | 662. BY WHOM | | 663. IN PRESENCE OF | | 664. WITNESSES | | 665. SIGNATURE | | 666. DATE | | 667. TIME | | 668. PLACE | | 669. BY WHOM | | 670. IN PRESENCE OF | | 671. WITNESSES | | 672. SIGNATURE | | 673. DATE | | 674. TIME | | 675. PLACE | | 676. BY WHOM | | 677. IN PRESENCE OF | | 678. WITNESSES | | 679. SIGNATURE | | 680. DATE | | 681. TIME | | 682. PLACE | | 683. BY WHOM | | 684. IN PRESENCE OF | | 685. WITNESSES | | 686. SIGNATURE | | 687. DATE | | 688. TIME | | 689. PLACE | | 690. BY WHOM | | 691. IN PRESENCE OF | | 692. WITNESSES | | 693. SIGNATURE | | 694. DATE | | 695. TIME | | 696. PLACE | | 697. BY WHOM | | 698. IN PRESENCE OF | | 699. WITNESSES | | 700. SIGNATURE | | 701. DATE | | 702. TIME | | 703. PLACE | | 704. BY WHOM | | 705. IN PRESENCE OF | | 706. WITNESSES | | 707. SIGNATURE | | 708. DATE | | 709. TIME | | 710. PLACE | | 711. BY WHOM | | 712. IN PRESENCE OF | | 713. WITNESSES | | 714. SIGNATURE | | 715. DATE | | 716. TIME | | 717. PLACE | | 718. BY WHOM | | 719. IN PRESENCE OF | | 720. WITNESSES | | 721. SIGNATURE | | 722. DATE | | 723. TIME | | 724. PLACE | | 725. BY WHOM | | 726. IN PRESENCE OF | | 727. WITNESSES | | 728. SIGNATURE | | 729. DATE | | 730. TIME | | 731. PLACE | | 732. BY WHOM | | 733. IN PRESENCE OF | | 734. WITNESSES | | 735. SIGNATURE | | 736. DATE | | 737. TIME | | 738. PLACE | | 739. BY WHOM | | 740. IN PRESENCE OF | | 741. WITNESSES | | 742. SIGNATURE | | 743. DATE | | 744. TIME | | 745. PLACE | | 746. BY WHOM | | 747. IN PRESENCE OF | | 748. WITNESSES | | 749. SIGNATURE | | 750. DATE | | 751. TIME | | 752. PLACE | | 753. BY WHOM | | 754. IN PRESENCE OF | | 755. WITNESSES | | 756. SIGNATURE | | 757. DATE | | 758. TIME | | 759. PLACE | | 760. BY WHOM | | 761. IN PRESENCE OF | | 762. WITNESSES | | 763. SIGNATURE | | 764. DATE | | 765. TIME | | 766. PLACE | | 767. BY WHOM | | 768. IN PRESENCE OF | | 769. WITNESSES | | 770. SIGNATURE | | 771. DATE | | 772. TIME | | 773. PLACE | | 774. BY WHOM | | 775. IN PRESENCE OF | | 776. WITNESSES | | 777. SIGNATURE | | 778. DATE | | 779. TIME | | 780. PLACE | | 781. BY WHOM | | 782. IN PRESENCE OF | | 783. WITNESSES | | 784. SIGNATURE | | 785. DATE | | 786. TIME | | 787. PLACE | | 788. BY WHOM | | 789. IN PRESENCE OF | | 790. WITNESSES | | 791. SIGNATURE | | 792. DATE | | 793. TIME | | 794. PLACE | | 795. BY WHOM | | 796. IN PRESENCE OF | | 797. WITNESSES | | 798. SIGNATURE | | 799. DATE | | 800. TIME | | 801. PLACE | | 802. BY WHOM | | 803. IN PRESENCE OF | | 804. WITNESSES | | 805. SIGNATURE | | 806. DATE | | 807. TIME | | 808. PLACE | | 809. BY WHOM | | 810. IN PRESENCE OF | | 811. WITNESSES | | 812. SIGNATURE | | 813. DATE | | 814. TIME | | 815. PLACE | | 816. BY WHOM | | 817. IN PRESENCE OF | | 818. WITNESSES | | 819. SIGNATURE | | 820. DATE | | 821. TIME | | 822. PLACE | | 823. BY WHOM | | 824. IN PRESENCE OF | | 825. WITNESSES | | 826. SIGNATURE | | 827. DATE | | 828. TIME | | 829. PLACE | | 830. BY WHOM | | 831. IN PRESENCE OF | | 832. WITNESSES | | 833. SIGNATURE | | 834. DATE | | 835. TIME | | 836. PLACE | | 837. BY WHOM | | 838. IN PRESENCE OF | | 839. WITNESSES | | 840. SIGNATURE | | 841. DATE | | 842. TIME | | 843. PLACE | | 844. BY WHOM | | 845. IN PRESENCE OF | | 846. WITNESSES | | 847. SIGNATURE | | 848. DATE | | 849. TIME | | 850. PLACE | | 851. BY WHOM | | 852. IN PRESENCE OF | | 853. WITNESSES | | 854. SIGNATURE | | 855. DATE | | 856. TIME | |
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in only within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12704

Reg. Dist. No.

| | | | | | |
|--|------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN 1b <u>2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 239-F</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>aa</u> Same <u>Same</u> b. COUNTY <u>MD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Same Severna Park</u> d. STREET ADDRESS <u>Same Box 2397</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael James Whitaker</u> | | | 4. DATE OF DEATH Month Day Year <u>December 20th. 19 57</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/8/57</u> | | 9. AGE (In years last birthday) yrs. <u>4</u> Months <u>12</u> Days <u>12</u> Hours <u>Min.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Abington, Va.</u> | |
| 13. FATHER'S NAME <u>Luther Ray Whitaker</u> | | | 14. MOTHER'S MAIDEN NAME <u>Betty Irene Greer</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>The Parents. Luther R Whitaker</u> (2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Infection</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>1/3 sudden</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Gustave H. Faubert</u> | | M.D. <u>Gustave H. Faubert, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>12/20/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12-21-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Noel Craig Cent</u> | |
| 22d. LOCATION (City, town, or county) | | 22e. (State) | | 22f. (Country) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> | | ADDRESS <u>1000 S. ...</u> | | 24a. REC'D BY REGISTRAR DATE <u>12/23/57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

STATE OF
HEALTH

12312

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

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BUREAU V. S.

DEC 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12713 CERTIFICATE OF DEATH

12705

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u> | | c. LENGTH OF STAY IN 1b <u>8 mo, 30 das.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville, State Hospital, Md.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Williams</u> Last <u>Williams</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>19 57</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/2/02</u> |
| 9. AGE (In years last birthday) <u>55</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u> Hours <u>19</u> Min. <u>57</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Alfred Williams</u> | | 14. MOTHER'S MAIDEN NAME <u>Josephine Hicks</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>-----</u> | |
| 17. INFORMANT <u>Hospital Record</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensated Cardiac Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mitral Stenosis</u> DUE TO (c) <u>-----</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic Reaction, Paranoid Type</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-----</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u> | | 20f. (City or town) (County) (State) <u>-----</u> | |
| 21. I certify that I attended the deceased from <u>March 3</u> , 19 <u>57</u> , to <u>December 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>-----</u> , 19 <u>57</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>12/2/57</u> | | | |
| ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> | | M.D. <u>Crownsville, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> | | <u>Crownsville State Hospital, Md.</u> | |
| 22a. BURIAL-CREATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/6/1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Kate R. Williams</u> | | ADDRESS <u>322 N. Schroeder St</u> | |
| 24a. REC'D BY REGISTRAR <u>-----</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. M. Joyce</u> | |

1000

doi:10.1017/S0007122612000069

BUREAU V. S.

DEC 6 1957

RECEIVED

12714

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>CROWNSVILLE</u> | | c. LENGTH OF STAY IN 1b <u>75 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSVILLE State</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>BONIFACE</u> First <u>J</u> Middle <u>YOUNG</u> Last | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>17</u> Year <u>1957</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/2/79</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITER</u> | | 10b. KIND OF POSSESSION OR INDUSTRY <u>UNKNOW</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME <u>Susan Doughty</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | |
| 17. INFORMANT <u>Everett B. Saunders</u> Address <u>407 Robert St, Balto</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM AND EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>10-12 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9-24-1957</u> to <u>12-7-1957</u> , that I last saw the deceased alive on <u>12-6-1957</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Ludwig Benedict</u> M.D. | | ADDRESS (Street, city or town, state) <u>CROWNSVILLE STATE HOSPITAL</u> | |
| PHYSICIAN'S NAME (Type) <u>LUDWIG BENEDICT</u> | | DATE SIGNED <u>CROWNSVILLE STATE HOSPITAL</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 22b. DATE THEREOF <u>12-10-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Calverton Mem PK</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan</u> ADDRESS <u>Balto</u> | | 24a. REC'D BY REGISTRAR <u>DEC 9 1957</u> 24b. REGISTRAR'S SIGNATURE <u>M. Joyce</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 9 1957

BUREAU V. 2

1957

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

1957

1. NAME OF DECEASED: *John V. Smith*

2. SEX: *M*

3. AGE: *45*

4. DATE OF BIRTH: *1912*

5. PLACE OF BIRTH: *St. Louis, Mo.*

6. OCCUPATION: *Engineer*

7. CAUSE OF DEATH: *Heart Disease*

8. PLACE OF DEATH: *Home*

9. DATE OF DEATH: *Dec 8, 1957*

10. SIGNATURE OF PHYSICIAN: *John V. Smith*

11. SIGNATURE OF REGISTRAR: *John V. Smith*

12. SIGNATURE OF DECEASED: *John V. Smith*

13. SIGNATURE OF WITNESSES: *John V. Smith*

14. SIGNATURE OF FUNERAL HOME: *John V. Smith*

15. SIGNATURE OF BURIAL PLACE: *John V. Smith*

16. SIGNATURE OF INTERMENT PLACE: *John V. Smith*

17. SIGNATURE OF CREMATION PLACE: *John V. Smith*

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